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Project Information Document (PID)

Appraisal Stage | Date Prepared/Updated: 19-Oct-2023 | Report No: PIDIA00332

Public Disclosure Authorized

BASIC INFORMATION

A. Basic Project Data

Project Beneficiary(ies)	Region	Operation ID	Operation Name
Moldova	EUROPE AND CENTRAL ASIA	P180306	Modernization and Improvement of Rehabilitation Services Project
Financing Instrument	**Estimated Appraisal Date**	**Estimated Approval Date**	**Practice Area (Lead)**
Investment Project Financing (IPF)	11-Oct-2023	05-Mar-2024	Health, Nutrition & Population
Borrower(s)	**Implementing Agency**		
Republic of Moldova	Ministry of Health		

Proposed Development Objective(s)

The PDO is (i) to strengthen NCD care by improving prevention and rehabilitation services for NCDs, with a focus on stroke and heart attacks, at all levels of the health system, and (ii) in case of an Eligible Crisis or Emergency, respond promptly and effectively to it.

Components

Component 1: Integrated care at the hospital level for NCD patients
Component 2: Integrated prevention and rehabilitation services at the primary care and population-level
Component 3: Project management
Component 4: Contingent Emergency Response Component

PROJECT FINANCING DATA (US$, Millions)

Maximizing Finance for Development

Is this an MFD-Enabling Project (MFD-EP)?	No
Is this project Private Capital Enabling (PCE)?	No

SUMMARY

Total Operation Cost	**40.00**
Total Financing	**40.00**
of which IBRD/IDA	**40.00**

Financing Gap	**0.00**

DETAILS

World Bank Group Financing

International Bank for Reconstruction and Development (IBRD)	40.00

Environmental And Social Risk Classification

Moderate

Decision

The review did authorize the team to appraise and negotiate

Other Decision (as needed)

B. Introduction and Context

Country Context

1. **Moldova is a small lower-middle-income country, with a per capita gross national income of US$4,676 in 2020 and a ranking of 80 out of 198 countries in the Human Development Index in 2021.**[1] In 2019, 14.7 percent of its 2.57 million population lived below the poverty line of US$6.85 per day at purchasing power parity (PPP).[2] Despite solid economic performance over the past two decades, with a gross domestic product (GDP) per capita growing at an average rate of 5.14 percent per year, Moldova remains among the poorest countries in Europe.[3] From 2015 to 2021, the country went through six governments, and this volatility has hampered reforms to support a sustainable and inclusive long-term growth agenda.[4] In addition, the COVID-19 pandemic revealed vulnerabilities in Moldova's economic model. With a decline in GDP of more than seven percent in 2020, the economic consequences of COVID-19 and drought have been severe. The shock has had a large and heterogeneous impact on households, firms, sectors, and geographical areas. Poverty (using the national poverty line) rose from 25.2 percent in 2019 to 26.8 percent in 2020 due to lost earnings, reduced remittances, and the return of vulnerable migrants from abroad who might struggle to find

[1] World Bank, World Development Indicators Database, https://databank.worldbank.org/source/world-development-indicators; United Nations Development Programme, Human Development Index, https://hdr.undp.org/data-center/human-development-index#/indicies/HDI.
[2] World Bank, World Development Indicators Database.
[3] World Bank, World Development Indicators Database.
[4] World Bank, "Moldova 2021 SCD Update," 11.

employment.[5] As a result of the economic rebound in 2021, poverty fell to 24.5 percent.[6]

2. **The Russian invasion of Ukraine in February 2022 has further amplified these vulnerabilities.** High levels of food and energy inflation have sharpened preexisting concerns. Moldova is acutely reliant on natural gas from Russia, so import disruptions are expected to increase price pressures, eroding the competitiveness of firms and household incomes, especially for the poor. Many more Moldovans are at risk of falling or being pushed deeper into poverty. Rapidly rising inflation limits the purchasing power of pensions, social assistance, and wages. In addition, Moldova is currently supporting 116,000 Ukrainian refugees, 90 percent of whom are women and children.[7]

3. **Having gained candidate status to the European Union (EU) in June 2022, and the Government of the Republic of Moldova's (GoM) approach towards accession recognizes the importance of human development.** The National Development Strategy "European Moldova 2030" (NDS),[8] has an ambitious, forward-looking reform agenda. It calls for a shift from the current consumption-based growth model toward one based on raising investment, increasing productivity and competitiveness, and promoting a knowledge-based society. The NDS has prioritized sustainable and inclusive economic development, long-term human and social capital, and honest and efficient institutions.

4. **Improving healthcare service delivery goes hand in hand with realizing the NDS, given that health outcomes lag other countries and are not on par with the size of the GoM's health expenditures.** Healthcare costs will likely grow if preventive and low-cost technologies are not expanded, given Moldova's aging population, rising noncommunicable disease (NCD) burden, dilapidated hospital infrastructure, and interest in incorporating new (often expensive) technologies. Out-of-pocket (OOP) expenditures on health are high, disproportionally affecting low-income households. Hospitals need to become more efficient and deliver greater value for money, while primary healthcare (PHC) services need to cost effectively manage a growing chronic disease burden.

Sectoral and Institutional Context

5. **Moldova's health outcomes are slightly better than expected for its level of economic development.** The country's life expectancy at birth (74.3 years) and healthy life expectancy (65.1 years) are higher than middle-income countries in Europe and Central Asia (ECA), on average.[9] Since 2010, Moldova's premature mortality rate, defined as deaths occurring before age 70, has declined by 15 percent, outpacing the average rate of decline in ECA over the same period (six percent). But despite this encouraging trend, premature mortality rates in Moldova (456 per 100,000 population in 2019) remain nearly 50 percent higher than in ECA (307 per 100,000 population in 2019).[10]

6. **NCDs are the major burden of morbidity and mortality for the population and constitute the bulk of premature mortality in Moldova.** Compared to middle-income ECA countries, Moldova has one of the

[5] World Bank, "Moldova 2021 SCD Update," 27.
[6] World Bank, "Moldova 2021 SCD Update," 27.
[7] https://data.unhcr.org/en/situations/ukraine/location/10784
[8] GoM, "The National Development Strategy 'European Moldova 2030' Was Approved by the Government" [in Romanian], September 23, 2022, https://gov.md/ro/content/strategia-nationala-de-dezvoltare-moldova-europeana-2030-fost-aprobata-de-guvern.
[9] World Bank, WDI.

highest age-standardized premature mortality rates due to NCDs. NCD mortality is driven largely by cardiovascular diseases (CVDs), which caused 57 percent of all deaths and 37 percent of deaths before age 70 in 2019. Circulatory system diseases, cancers, diabetes, and respiratory diseases are also responsible for approximately four out of 10 primary disabilities – the major or overriding disability condition that characterizes an individual's impairment. The age-standardized mortality rates from ischemic heart disease and stroke have decreased markedly in the last two decades, while deaths from respiratory diseases have plateaued since 2012 and other main causes of death have remained relatively stable. Nevertheless, CVDs remains the main cause of mortality.

7. **While public expenditure on health in Moldova (60 percent of total health expenditure) is slightly above the upper-middle-income country average (56 percent), the proportion of total health expenditure paid for by households OOP is high, hindering financial risk protection.** In 2019, Moldovan households contributed nearly 36 percent of total health expenditure through OOP payments (US$170 per capita), with 19 percent of households spending more than 10 percent of their annual income on OOP health payments—termed catastrophic spending.[11] OOP payments are largely used to finance drugs, and high OOP payments negatively impact healthcare utilization rates and medication adherence, particularly for the poorest households.

8. **Weaknesses in service delivery for people with NCDs, particularly CVDs, are apparent in PHC settings and drive the demand for services in costly, tertiary settings.** In 2019, hypertension accounted for nearly 37 percent of all deaths in Moldova,[12] and the Moldovan PHC system has been unable to manage hypertension in the population sufficiently. Detection is improving, but only half of patients adhere to long-term antihypertensive treatment despite drug availability. As a result, 87 percent of patients with hypertension have uncontrolled blood pressure.

9. **When patients experience an acute cardiovascular event like stroke or heart attack, many cannot access appropriate specialized treatment quickly.**[13] The results of a study on access to care showed that 33 percent of patients did not access health care when needed, and 20 percent of them cited lack of affordability as the reason.[14] CVD patients tend to present late for hospital care. Low awareness among the population of the warning signs and the benefits of early treatment may contribute to this issue, along with perceived or real financial barriers.

10. **Too few stroke patients are treated in facilities with the appropriate monitoring and infrastructure.**[15] In September 2022, nationally, only 31 percent of stroke patients were treated in a stroke unit. At the Institute of Emergency Medicine, 73 percent of stroke patients were treated in a stroke unit, compared with 7 percent in Cahul and Edinet District Hospitals.[16] For patients with acute myocardial infarction

[11] OOP spending greater than 10 percent of annual income.
[12] Global Burden of Disease Collaborative Network, *Global Burden of Disease Study 2019*.
[13] M. Skarphedinsdottir et al., "Better noncommunicable disease outcomes challenges and opportunities for health systems, n°4: Republic of Moldova Country Assessment," *World Health Organization. Regional Office for Europe 2014.* https://apps.who.int/iris/handle/10665/129636
[14] Skarphedinsdottir et al. *Moldova Country Assessment 2014.*
[15] A. Cieza et al., "Global Estimates of the Need for Rehabilitation Based on the Global Burden of Disease Study 2019: A Systematic Analysis for the Global Burden of Disease Study 2019," *The Lancet* 396, no. 10267 (December 2021): 2006–17, https://doi.org/10.1016/S0140-6736(20)32340-0.
[16] Registry of Stroke Care Quality (RES-Q) database, https://qualityregistry.eu/ (provided by MoH)

(AMI or heart attack), mortality rates are high (30–35 percent), and thrombolytic therapy[17] is not routinely administered.[18] Restorative rehabilitation services are provided in four overburdened hospitals, with waiting times of up to three months.

11. **There are four categories of rehabilitation: preventive, restorative, supportive, and palliative.** Preventive rehabilitation occurs shortly after a new diagnosis or the onset of new impairments. The aim is to provide education, advice, and interventions to prevent or slow the onset of impairments and maintain a person's ability level. Restorative rehabilitation focuses on interventions that improve impairments, such as those to muscle strength, respiratory function, or cognition, to get maximal recovery of function. This is a common form of rehabilitation after surgery, illness, or acute events, such as a major trauma or a stroke, to recover diminished functionality. Supportive or "adaptive" rehabilitation increases a person's self-care ability and mobility by, for example, providing self-help devices or teaching compensatory strategies – alternative ways of doing things – and may include providing assistive equipment or environmental modifications. Palliative rehabilitation enables people with life-limiting conditions to lead a high quality of life physically, psychologically, and socially while respecting their wishes. It often focuses on relieving symptoms to maximize functional independence and support comfort, dignity, and quality of life.

12. **About 43 percent of Moldovans may need rehabilitation services, and the MoH estimates that the unmet need for rehabilitation services is 70 percent**.[19] In 2022, the WHO estimated that 1.6 million Moldovans had at least one condition that would benefit from rehabilitation services. The largest share of the population in need was between 15 and 64 years, with relatively equal needs between men and women. Women over 65 years have a higher burden of conditions (1.6 times higher) than men. Since 2012, demand for rehabilitation services steadily increased, but the lack of service provision and long waiting times mean patients are often discharged after being stabilized. As a result, approximately 90 percent of these patients do not return to the workforce.

C. Proposed Development Objective(s)

Development Objective(s) (From PAD)

13. The PDO is to (i) strengthen NCD care by improving prevention and rehabilitation services for NCDs, with a focus on stroke and heart attacks, at all levels of the health system, and (ii) in case of an Eligible Crisis or Emergency, respond promptly and effectively to it.

Key Results

PDO Elements	PDO Indicators
PDO Indicator 1: NCD prevention and management in primary care facilities	**Primary care facilities following standardized protocols and guidelines for screening, prevention and management of hypertension and diabetes. (Percentage)**

[17] Harvey D. White and Frans J. J. Van de Werf, "Thrombolysis for Acute Myocardial Infarction," *Circulation* 97, no. 16 (1998): 1632–46, https://doi.org/10.1161/01.CIR.97.16.1632.
[18] Skarphedinsdottir et al. 2014.
[19] WHO, *The Need for Rehabilitation Services in the WHO European Region* (Copenhagen: WHO Regional Office for Europe, 2022).

PDO Elements	PDO Indicators
PDO Indicator 2: Timely stroke treatment	**Eligible stroke patients who are treated within with systemic thrombolysis, within 2 hours, in Project-supported facilities (Percentage)**
PDO Indicator 3: Facility-readiness for stroke management	**Percentage increase in patients with a stroke who are treated in fully equipped, dedicated stroke units in Project-supported facilities. (Percentage)**
PDO Indicator 4: Restorative rehabilitation for stroke and cardiac care	**Stroke and cardiac patients who received restorative rehabilitation services (Percentage)**

D. Project Description

14. The proposed Project has the following four components that will strengthen services for emergency care to diagnose and promptly treat patients with acute healthcare needs, such as a heart attack of stroke.

15. **Component 1: Integrated care at the hospital level for NCD patients.** This component will focus on patients facing catastrophic health events, primarily strokes and heart attacks. It will: (1) strengthen emergency response capabilities following catastrophic health events, focusing on strokes and AMI; and (2) develop and upgrade health facilities and equipment. It will support improvements in the quality, efficiency, and accessibility of rehabilitation services, focusing on patients following an acute episode requiring intensive rehabilitation services. The component will finance technical assessments to determine the level and type of building work required,[20] equipment, infrastructure improvements, and transportation,[21] with an initial focus on ten facilities and, thereafter, up to thirty additional facilities.[22] The renovations, including modifications of rooms and facilities, such as the introduction of railings and non-slip flooring, are to provide appropriate facilities and a conducive environment to support patients, including those with disabilities, in need of restorative rehabilitation. This component will also finance equipment and service improvements for selected related service lines,[23] where doing so would constitute a cost-effective investment alongside stroke and cardiac care rehabilitation improvements. Additionally, the component will finance the development and uptake of protocols to triage, assess, and manage the care of patients immediately following a substantial trauma, such as a stroke or heart attack; training to support healthcare workers in rapidly identifying strokes and heart attacks; diagnostic equipment; and emergency transport for patients in need of complex care—to safely transfer them in a timely manner to the appropriate level of the health system.

16. **Component 2: Integrated prevention and rehabilitation services at the primary care and population-level.** This component will support services to prevent NCDs through primary care and population-level interventions. The purpose of these interventions at the individual level is to limit the likelihood of an initial

[20] Additional facility assessments will be conducted by the World Health Organization, as part of their rehabilitation services work program of support.

[21] This includes the provision of transportation between facilities, which would be incorporated into financing mechanisms for rehabilitation services following the Project.

[22] The following District Hospitals (Anenii Noi, Basarabeasca, Briceni, Cahul, Călăraşi, Cantemir, Căuşeni, Cimişlia, Cărpineni Hospital, Criuleni, Spitalul Raional Donduseni, Drochia, Edineţ, Floreşti, Făleşti, Glodeni, Hînceşti, Ialoveni, Leova, Nisporeni, Ocniţa, Orhei, Rezina, Rîşcani, Sîngerei, Şoldăneşti, Soroca, Spitalul Raional Ştefan Vodă, Străşeni, Taraclia, Teleneşti, Ungheni, Vulcăneşti) as well as CRRC, Clinical Hospital of the Ministry of Health, Clinical Department No.1 (51 Pushkin Street), Clinical Department no.2 (Gh. Caşu 37).

[23] These service lines could include pediatric trauma, physiotherapy, neurology, cardiology, speech therapy, nutrition, oncology services for patients with NCDs, psychiatry, and geriatrics.

acute episode, and at the system level, to limit the use of costly tertiary services. It will focus on patients at risk of strokes and heart attacks and, recognizing the presence of comorbidities, will also include programming for other NCDs. The component will also strengthen preventive and supportive rehabilitation services to support patients following a stroke or heart attack. The purpose of this investment is to address a gap in service provision and better preserve the human capital of patients who have experienced an acute episode. In addition, preventive and supportive rehabilitation are two areas where integration within and across sectors stands to improve the service quality.

17. **Subcomponent 2.1. Primary care and population-level interventions for NCD prevention and management.** This subcomponent will finance NCD prevention and disease management programs for Moldovans, including screening and treatment; training for healthcare workers to better manage chronic disease conditions and to detect the early signs of strokes and cardiac episodes; public awareness campaigns to address the major risk factors for stroke and heart attacks, including hypertension, salt consumption, physical inactivity, and diet; and scale-up existing telemedicine and digital health programs to improve access to counseling to address risk factors for vulnerable populations.

18. **Subcomponent 2.2. Preventive and supportive rehabilitation services.** This subcomponent will finance the development of materials and training to support the utilization of protocols for the integration of multidisciplinary care for cardiac and stroke patients, strengthening of digital infrastructure between facilities to support the integration of rehabilitation services, discharge planning and protocols from secondary to primary care; rehabilitation support materials; and the development of home-based care models to minimize unnecessary and prolonged hospital-based treatment.

19. **Component 3: Project management.** This component will support project management, coordination, and monitoring and evaluation activities, including third party monitoring. It will finance the Project Implementation Unit (PIU), consulting services, office equipment, training, audits, filing systems, and operating costs.

20. **Component 4: Contingent Emergency Response (CERC).** The objective of this component is to improve Moldova's capacity to respond to natural and man-made disasters. Following an eligible crisis or emergency, the Recipient may request the World Bank to reallocate Project funds to support emergency response and reconstruction. This component would draw from the uncommitted grant resources under the Project from other Project components to cover emergency response.

Legal Operational Policies	Triggered?
Projects on International Waterways OP 7.50	No
Projects in Disputed Area OP 7.60	No

Summary of Screening of Environmental and Social Risks and Impacts

21. Environmental risks and impacts are mostly associated with project-related civil works and healthcare facilities operation. These risks are site-specific and temporary and can be mitigated by existing construction best practices. Social risks involve potential for exclusion in access to services for members of vulnerable groups, especially the disabled and isolated rural poor, and those without awareness or insurance. Principles of universal access will inform physical design, safety and emergency protocols, and access to health services to facilitate improvements in inclusion of patients with different needs. There is some risk that the most vulnerable patients may suffer neglect or abuse in institutionalized medical settings during the provision of healthcare services although incidents are likely to be isolated and are preventable through training, codes of conduct, labor management procedures, stakeholder engagement and grievance mechanisms.

E. Implementation

Institutional and Implementation Arrangements

22. The PIU will be responsible for managing Project implementation, including procurement of medical supplies and equipment and facility refurbishment for activities under the Project. The PIU will also prepare project progress reports (technical, financial and procurement) and an annual work plan with inputs from the MoH. All reporting and oversight relationships will be summarized in the POM. The PIU of the current Moldova Emergency COVID-19 Operation will be strengthened with additional staff to cover key functional roles. Given their previous experience, building on the foundation of the current PIU is intended to enhance the likelihood of successful Project implication. The PIU will also recruit a dedicated Project Coordinator and Procurement Specialist and extend the existing contracts. Financial management (FM) will be carried out by a full-time FM specialist. Procurement will be implemented by a Procurement Specialist with experience in international procurement and a track record of ensuring steady implementation on multiple projects financed by international financial institutions. Compliance with World Bank environmental and social policies will be the responsibility of the MoH, with support from one social development specialist and one environmental specialist in the PIU. All reporting and oversight relationships will be summarized in the POM.

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