Program Information Documents (PID)

Appraisal Stage | Date Prepared/Updated: 27-Mar-2023 | Report No: PIDA270807

BASIC INFORMATION

A. Basic Program Data

Country	Project ID	Program Name	Parent Project ID (if any)
Kyrgyz Republic	P178856	Primary Health Care Quality Improvement Program - Additional Financing	P167598
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
EUROPE AND CENTRAL ASIA	11-Apr-2023	31-May-2023	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Program-for-Results Financing	Ministry of Finance	Ministry of Health, Mandatory Health Insurance Fund	

Program Development Objective(s)

The Program Development Objective is to contribute to improving the quality of primary health care services in the Kyrgyz Republic.

COST & FINANCING

SUMMARY (USD Millions)

Government program Cost	357.34
Total Operation Cost	30.60
Total Program Cost	19.15
IPF Component	11.45
Total Financing	30.60
Financing Gap	0.00

FINANCING (USD Millions)

Total Government Contribution	19.15
Total Non-World Bank Group and Non-Client Government Financing	11.45
Trust Funds	11.45

B. Introduction and Context

Sectoral and Institutional Context

1. **Health has traditionally been a priority in the Kyrgyz Republic, and the country has achieved better health outcomes than other countries with similar income level.** The population enjoys a longer life expectancy of 71.8 years in 2020, partly due to the significant progress in reducing under-5 mortality from 65.8 deaths per 1,000 live births in 1990 to 17.5 in 2020. In 2015, the country officially achieved the Millennium Development Goal No. 4 on reducing mortality among children under five. However, the health system is still primarily financed by out-of-pocket (OOP) spending, which accounted for 46.2 percent of health expenditure in 2019. The prioritization of health in Government spending has varied substantially over time. Between 2000 and 2012, current health spending increased from 4.4 percent of Gross Domestic Product (GDP) to 8.5 percent. However, current health spending subsequently decreased again to 4.5 percent of GDP in 2019, in line with a substantial decrease in domestic general government health expenditure, which went from 4.2 percent of GDP in 2012 to 2.3 percent in 2019.

2. **The COVID-19 pandemic negatively impacted the delivery of routine health services and the population's health.** Childhood immunization rates against Diphtheria-Polio-Tetanus, Hib[1], and HepB[2] dropped by 8 to 9 percentage points in 2020, and preliminary data suggest that they did not fully rebound in 2021, especially for the youngest age groups (children aged 1). Maternal mortality increased from 24.8 per 100,000 live births in 2019 to 36.1 per 100,000 live births in 2020, reversing four years of progress on that indicator.[3] Access to contraceptives decreased by 1.7 times between 2016 and 2020, with even sharper decreases in some geographical areas such as Osh (5.6 times decrease) and Talas Province (2.4 times).[4]

3. **Despite the progress in health indicators, the trends in primary health care (PHC) in the Kyrgyz Republic are concerning.** First, the reported utilization of primary care is low and declining. Even before the COVID-19 pandemic, the number of outpatient contacts per person per year was trending downward from an already low level of approximately 4 in the early 2000's to 2.5 in 2019. The downward trend has continued and resulted in an average of 1.6 visits in 2021. This decline points to issues of availability and quality of care, low trust in the system, and suboptimal functioning of information systems.

4. **Ensuring the population's access to essential health services and prioritizing accessible, effective, and affordable PHC services are critical going forward.** Service availability suffers from high vacancy rates, particularly at the PHC level, partly due to perverse incentives that deter health facilities from filling vacant positions. PHC institutions' capacity to diagnose and resolve health problems is low due to the limited availability of diagnostic services (laboratory tests, medical imaging, etc.), lack of medical staff training, and limited financing of outpatient medicines. Meanwhile, the hospital system is mostly outdated in its model of care and infrastructure. Substantial investments would be needed to move towards more effective approaches, such as day surgery and evidence-based medicine. **On the health financing side, there is a need to develop further the health financing tools, including the State Guaranteed Benefits Package (SGBP) and**

[1] Haemophilus Influenzae type b
[2] Hepatitis B
[3] National Statistical Committee, 2022, *http://www.stat.kg/en/opendata/category/5/*, accessed June 10, 2022.
[4] UNFPA, 2021, Report on Situation Analysis of Reproductive Health, kyrgyzstan.unfpa.org.

provider payment methods. The Kyrgyz Republic was a pioneer among former Soviet countries in introducing a purchasing agency, the Mandatory Health Insurance Fund (MHIF, usually referred to by its Russian acronym FOMS), and new provider payment mechanisms beginning in the 1990s. However, many of those reforms have not yet resulted in full access of the population to a basic package of services. Out-of-pocket expenditures continue to represent almost half of the total health expenditures in the country, exposing the population to the risk of impoverishment and catastrophic health expenditures. To reap the full benefits of the reforms, the country would need to move towards a more explicit, poverty-driven benefits package and more modern provider payment methods based on outputs.

5. **The Program-for-Results (PforR) (or the Program) supports the program of the Kyrgyz Government on Public Health Protection and Health Care System Development for 2019-2030 "Healthy Person - Prosperous Country,"** also known as the State Program of Health Development 2030 (SPHD2030). The SPHD2030 was approved in December 2018 and outlines directions for health sector reform in 2019-2030, building on achievements and lessons from the three earlier programs ('Manas', 'Manas-Taalimi', and 'Den Sooluk'). The program is in line with the Government's international commitments to health (i.e., Sustainable Development Goals (SDG) and Health 2020). Some of the stated program goals are to improve health outcomes and quality of services, reduce inequities in health outcomes and financial protection, and strengthen public health. **The SPHD2030 identified ten priority program areas**. Four program areas relate to specific types of care: public health, PHC, hospital care, and ambulance service. The remaining six areas are cross-cutting and include laboratory services, medicines and medical devices, governance, human resources, electronic health (e-health), and financing. Each program area has several sub-areas/objectives with priority actions and indicators. The PHC area, for instance, includes capacity building, quality improvement, care coordination, and prevention, early detection, and case management of non-communicable diseases (NCDs). Up to five activities and outputs accompany each sub-area/objective.

PforR Program Scope

6. **The Program aims to support the first five years of implementation of the SPHD2030 in area #2 of the development of PHC.**The Program focuses on establishing and strengthening PHC quality-of-care monitoring, purchasing, and governance systems to build and strengthen foundations for sustainable system-wide quality improvement. Cross-cutting areas of the SPHD2030 form part of the Program to the extent that they relate directly to PHC. For example, a significant element of quality at the PHC level is the competence of family medicine doctors, which is included in the Human Resources for Health (HRH) component. The Program seeks to improve the competence of family medicine doctors but does not attempt to address a full array of issues related to HRH. Likewise, the Program supports the development of a system for collecting and analyzing PHC quality data. Still, it does not attempt to comprehensively address the e-health plan, which requires significantly more targeted efforts and investment. By the same logic, there could be some overlap between the Program and public health and hospital areas in elements that directly relate to the quality of PHC.

7. **At Program appraisal, the estimated committed total financing for the PHC area of the program for the five years 2020-2024 was US$ 414.18 million**. Of this amount, the estimated expenditure from the Republican Budget was US$ 377.18 million.[1] The amount appraised for the Program was US$ 37 million, of which US$ 20 million from the International Development Association's 18th round of replenishment (IDA-18) (US$ 10 million as grant and US$ 10 million as credit), with the remaining US$ 17 million financed through a Recipient-Executed Trust Fund (RETF) from the Primary Health Care Quality Improvement Program (PHCQIP) Multi-donor Trust Fund (MDTF) managed by the World Bank (WB). The RETF represents the first phase of co-financing from the MDTF, which was explicitly created to support the Program and is financed by two

development partners: the German Development Bank (Kreditanstalt für Wiederaufbau - KfW) and the Swiss Development Cooperation (SDC).

8. **The disbursement-linked indicators (DLIs) under the Program remain highly relevant to the development of the health sector in the Kyrgyz Republic.** The Program's three results areas respond to three continuing main challenges in the sector, and the general areas of work and DLIs under each results area do not require major modifications. However, in the first years of implementation it became clear that the Program is very ambitious for the existing implementation capacity.

9. **Restructuring of the Program is needed to align the Program's DLIs and disbursement-linked results (DLRs) with the current state of implementation and to remove bottlenecks to implementation.** First, the DLIs under the original Program featured hard deadlines and the financing agreement did not make any provisions in case of delays in achievement of the DLRs. Second, the Program boundary needs to be adjusted to allow the MHIF to spend Program proceeds on management and administration, in support of DLIs 5, 6, 7, and 8. Third, the results framework needs to be adjusted to scale down some overly ambitious goals. Fourth, the DLRs under the DLIs need to be revised to break down complex, composite objectives that take many years to achieve, and scale them down. In the case of DLIs 2 and 5, breaking complex objectives down will allow the Program to recognize two completed intermediate achievements. Finally, an extension of the closing date is necessary to allow the Program to achieve its ambitious objectives.

C. Program Development Objective(s)

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The Program Development Objective is to contribute to improving the quality of primary health care services in the Kyrgyz Republic.

The Program Development Indicators are:

	Baseline	End target
PDO 1: Number of pregnant women who received a hemoglobin test and urine analysis for bacteriuria during the first trimester in a public PHC facility or SESS lab (Number)	24,000.00	64,000.00
PDO 2: Number of patients with suspected or confirmed diabetes (type I or II) who receive an HbA1c test in a public PHC facility (Number)	0	35,000
PDO 3: Increase in drug coverage for priority conditions under the ADP, as measured by number of prescriptions reimbursed for (i) Test strips, (ii) Iron supplements, and (iii) Hypertension drugs (Text)	(i) 3,149 (ii) 169,480 (iii) 333,545	(i) 22,200 (ii) 1,224,000 (iii) 2,429,000
PDO 4: A unit fully designated to quality improvement is established within the Ministry of Health and functioning (Yes/No)	No	Yes

D. Environmental and Social Effects

10. A short **addendum to the Environmental and Social Systems Assessment (ESSA)** was prepared to identify any new potential environmental and social risks that may emerge from the Program restructuring and recommend any additional measures to further strengthen the environmental and social systems, if not already covered under the original ESSA. The draft addendum, together with the final ESSA, was disclosed, and consultations were undertaken with beneficiaries, users of health facilities, stakeholders representing patient rights, and other relevant stakeholders related to identified environmental and social actions prior to the appraisal.

11. An **Environmental and Social Commitment Plan (ESCP)** has been prepared for a new Investment Project Financing component of the operation (the Project) financed by the additional financing, in line with requirements under the Environmental and Social Framework. The Project risk is considered Low for the pertinent social aspects and Moderate for the environmental aspects. Environmental and Social Standards (ESSs) 1, 2, 3, 4, and 10 were identified as relevant. A standalone Stakeholder Engagement Plan (SEP) is not required. For the procurement of specialized waste transport vehicles, laboratory, and IT equipment to be financed under the Project, requirements for compliance with national health and safety, and environmental standards and international best practices must be included in the bidding documents, including safe disposal of the IT equipment at the end of their life cycle. In addition, standard operating procedures/codes of practice to safely operate, maintain, and repair equipment and dispose of waste, must be prepared. Environmental and Social Management Plan (ESMP) checklists to cover the minor renovations of the laboratories for the installation of the equipment will also need to be prepared. These requirements are reflected in the ESCP.

12. Communities and individuals who believe that they are adversely affected as a result of a Bank-supported operation, as defined by the applicable policy and procedures, may submit complaints to the existing Program grievance redress mechanism or the WB's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address pertinent concerns. Affected communities and individuals may submit their complaint to the WB's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WB non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate Grievance Redress Service (GRS), please visit http://www.worldbank.org/GRS. For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.

E. Financing

Sources	Amount (USD Million)	% of Total
Counterpart Funding	**19.15**	**62.58**
Borrower/Recipient	19.15	62.58
Trust Funds	**11.45**	**37.42**

Miscellaneous 1	9.05	29.58
Miscellaneous 2	2.40	7.84
Total Program Financing	**30.60**	

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CONTACT POINT

World Bank

Name :	Christel M. J. Vermeersch		
Designation :	Senior Economist	Role :	Team Leader(ADM Responsible)
Telephone No :	458-9554	Email :	cvermeersch@worldbank.org

Borrower/Client/Recipient

Borrower :	Ministry of Finance		
Contact :	Nurbek Akzholov	Title :	Head of the International Cooperation Department
Telephone No :	996771658511	Email :	n.akjolov@minfin.kg

Implementing Agencies

Implementing Agency :	Mandatory Health Insurance Fund		
Contact :	Azamat Mukanov	Title :	Director, Mandatory Health Insurance Fund (MHIF)
Telephone No :	996558151565	Email :	m_azamat@list.ru

Implementing Agency :	Ministry of Health		
Contact :	Bek Nogoibaev	Title :	Head of the Department of Strategic Planning and Reform Impl
Telephone No :	996312663707	Email :	b_nogoibaev@mz.med.kg

FOR MORE INFORMATION CONTACT

The World Bank
1818 H Street, NW
Washington, D.C. 20433
Telephone: (202) 473-1000
Web: http://www.worldbank.org/projects