



Report No: PAD00225

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT
ON A
PROPOSED CREDIT

IN THE AMOUNT OF EUR 18.60 MILLION
(US\$ 20 MILLION EQUIVALENT)

TO THE
REPUBLIC OF KOSOVO

FOR THE
KOMPAS - KOSOVO COMPREHENSIVE APPROACH TO HEALTH SYSTEM STRENGTHENING PROJECT
(P179831)

APRIL 16, 2024

Health, Nutrition & Population
Europe and Central Asia

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CURRENCY EQUIVALENTS

(Exchange Rate Effective March 31, 2024)

Currency Unit =		USD
EUR 1.00	=	US\$ 1.08
US\$1.00	=	EUR 0.93

FISCAL YEAR

January 1 - December 31

Regional Vice President: Antonella Bassani

Regional Director: Michal J. Rutkowski

Country Director: Xiaoqing Yu

Practice Manager: Rekha Menon

Task Team Leader(s): Ha Thi Hong Nguyen, Mrike Aliu

ABBREVIATIONS AND ACRONYMS

AMR	Antimicrobial Resistance
BHIS	Basic Health Information System
CAESAR	Central Asia and European Surveillance of AMR
DA	Designated Account
DALY	Disability-Adjusted Life Years
DFIL	Disbursement and Financial Information Letter
DHSC	Digital Health Steering Committee
ECA	Europe and Central Asia
ESF	Environmental and Social Framework
ESMF	Environmental and Social Management Framework
ESS	Environmental and Social Standard
EU	European Union
FM	Financial Management
GBV	Gender-based Violence
GDP	Gross Domestic Product
GGE	General Government Expenditure
GIZ	German Agency for Cooperation and Development
GRS	Grievance Redress Service
HAI	Healthcare-Associated Infections
HCW	Healthcare Waste
HCWM	Healthcare Waste Management
HIF	Health Insurance Fund
HIS	Health Information System
HMIS	Hospital Management Information System
IFR	Interim Unaudited Financial Reports
IHIS	Integrated Health Information System
IPC	Infection Prevention and Control
IPF	Investment Project Financing
IT	Information Technology
KAS	Kosovo Agency of Statistics
KFMIS	Kosovo Financial Management Information System
KHUCS	Kosovo Hospital and University Clinical Services
LIS	Laboratory Information Systems
MoFLT	Ministry of Finance, Labor and Transfers
MoH	Ministry of Health
NCD	Noncommunicable Diseases
NDC	Nationally Determined Contribution
NIPH	National Institute of Public Health
OOP	Out-of-Pocket
ODBP	Outpatient Drug Benefit Package
PCU	Project Coordination Unit
PDO	Project Development Objective
PFM	Public Financial Management
PHC	Primary Health Care
POM	Project Operations Manual
PPR	Pandemic Preparedness and Response

QA/QM	Quality Assurance/Quality Management
QoC	Quality of Care
SCD	Systematic Country Diagnostic
SDC	Swiss Agency for Development and Cooperation
SMC	Senior Management Committee
TA	Technical Assistance
UCCK	University Clinical Center of Kosovo
WBG	World Bank Group
WHO	World Health Organization



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DATASHEET

BASIC INFORMATION

Project Beneficiary(ies) Kosovo	Operation Name KOMPAS - Kosovo Comprehensive Approach to Health System Strengthening		
Operation ID P179831	Financing Instrument Investment Project Financing (IPF)	Environmental and Social Risk Classification Moderate	

Financing & Implementation Modalities

<input type="checkbox"/> Multiphase Programmatic Approach (MPA)	<input type="checkbox"/> Contingent Emergency Response Component (CERC)
<input type="checkbox"/> Series of Projects (SOP)	<input checked="" type="checkbox"/> Fragile State(s)
<input type="checkbox"/> Performance-Based Conditions (PBCs)	<input type="checkbox"/> Small State(s)
<input type="checkbox"/> Financial Intermediaries (FI)	<input type="checkbox"/> Fragile within a non-fragile Country
<input type="checkbox"/> Project-Based Guarantee	<input type="checkbox"/> Conflict
<input type="checkbox"/> Deferred Drawdown	<input type="checkbox"/> Responding to Natural or Man-made Disaster
<input type="checkbox"/> Alternative Procurement Arrangements (APA)	<input type="checkbox"/> Hands-on Expanded Implementation Support (HEIS)

Expected Approval Date 07-May-2024	Expected Closing Date 31-Mar-2029
Bank/IFC Collaboration No	

Proposed Development Objective(s)

The Project Development Objective (PDO) is to strengthen institutional capacity and governance for quality of care in the Kosovo health system.

Components



Component Name	Cost (US\$)
1. Strengthening key health system building blocks for quality of care	6,950,000.00
2. Developing an integrated health information system	12,200,000.00
3. Project Management, Monitoring, and Evaluation	850,000.00

Organizations

Borrower: Republic of Kosovo
 Implementing Agency: Ministry of Health

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	20.00
Total Financing	20.00
of which IBRD/IDA	20.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	20.00
IDA Credit	20.00

IDA Resources (US\$, Millions)



	Credit Amount	Grant Amount	SML Amount	Guarantee Amount	Total Amount
National Performance-Based Allocations (PBA)	20.00	0.00	0.00	0.00	20.00
Total	20.00	0.00	0.00	0.00	20.00

Expected Disbursements (US\$, Millions)

WB Fiscal Year	2024	2025	2026	2027	2028	2029
Annual	0.27	3.22	9.76	3.66	2.48	0.61
Cumulative	0.27	3.49	13.25	16.91	19.39	20.00

PRACTICE AREA(S)

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

CLIMATE

Climate Change and Disaster Screening

Yes, it has been screened and the results are discussed in the Operation Document

SYSTEMATIC OPERATIONS RISK- RATING TOOL (SORT)

Risk Category

Rating

1. Political and Governance	● Moderate
2. Macroeconomic	● Moderate
3. Sector Strategies and Policies	● Substantial
4. Technical Design of Project or Program	● Moderate



5. Institutional Capacity for Implementation and Sustainability	● Substantial
6. Fiduciary	● Moderate
7. Environment and Social	● Moderate
8. Stakeholders	● Moderate
9. Overall	● Moderate

POLICY COMPLIANCE

Policy

Does the project depart from the CPF in content or in other significant respects?

Yes No

Does the project require any waivers of Bank policies?

Yes No

ENVIRONMENTAL AND SOCIAL

Environmental and Social Standards Relevance Given its Context at the Time of Appraisal

E & S Standards	Relevance
ESS 1: Assessment and Management of Environmental and Social Risks and Impacts	Relevant
ESS 10: Stakeholder Engagement and Information Disclosure	Relevant
ESS 2: Labor and Working Conditions	Relevant
ESS 3: Resource Efficiency and Pollution Prevention and Management	Relevant
ESS 4: Community Health and Safety	Relevant
ESS 5: Land Acquisition, Restrictions on Land Use and Involuntary Resettlement	Not Currently Relevant
ESS 6: Biodiversity Conservation and Sustainable Management of Living Natural Resources	Not Currently Relevant
ESS 7: Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities	Not Currently Relevant
ESS 8: Cultural Heritage	Not Currently Relevant
ESS 9: Financial Intermediaries	Not Currently Relevant



NOTE: For further information regarding the World Bank’s due diligence assessment of the Project’s potential environmental and social risks and impacts, please refer to the Project’s Appraisal Environmental and Social Review Summary (ESRS).

LEGAL

Legal Covenants

Sections and Description

The Recipient, through the MOH, shall establish, not later than thirty (30) days from the Effective Date, and thereafter maintain at all times during Project implementation, a Senior Management Committee (SMC) for overall coordination and oversight of the Project, chaired by the MOH and comprised of different agencies responsible for both coordination and technical implementation, as further described in the Project Operations Manual (POM).

The Recipient, through the MOH, shall establish, not later than sixty (60) days from the Effective Date, and thereafter maintain at all times during Project implementation, a Digital Health Steering Committee (DHSC), responsible for digital health policy making, regulations, and health data governance under Part 2 of the Project, as further described in the POM.

The Recipient, through the MOH, shall establish, not later than thirty (30) days from the Effective Date, and thereafter operate and maintain, at all times during Project implementation, a PCU with structure, functions, and responsibilities acceptable to the Association, as set forth in the POM, including, inter alia, providing support for procurement, financial management and reporting on the use of Project funds, with resources and staffing (with qualifications, experience and under terms of reference) satisfactory to the Association.

The Recipient, through the MOH, shall, not later than thirty (30) days from Effective Date, develop and adopt and thereafter carry out the Project in accordance with the POM, which shall contain, inter alia: (i) detailed guidelines and procedures for the implementation of the Project, including with respect to the establishment of the PCU, its structure, functions, and responsibilities; Project administration and coordination; monitoring and evaluation; financial management; procurement and accounting; and environmental and social standards; (ii) corruption and fraud mitigation measures; (iii) a grievance redress mechanism; (iv) Personal Data collection and processing in accordance with good international practice; and (v) other arrangements and procedures.

Conditions

Type	Citation	Description	Financing Source



I. STRATEGIC CONTEXT

A. Country Context

1. Since its independence in 2008, Kosovo has made progress in institution building.¹ It has consolidated the functioning of its democratic institutions, held free and peaceful elections, and built legal frameworks to respect the rights of different ethnic and religious communities. Though Kosovo faced a period of repeated changes in government² that contributed to political instability, the February 2021 election was the first time since independence when a single party won over 50 percent of the vote. The formation of the current government in March 2021 has brought the needed political stability, and recent country-level polling has signaled an increase in trust in the government.³

2. As part of its state-building efforts, Kosovo is implementing an ambitious agenda, partly driven by aspirations of European Union (EU) membership. Its path to EU accession is an important opportunity for stabilization, universal recognition, and institutional development. While EU membership remains a distant goal, the accession process provides an important anchor for democratization, rule of law, public administration, and market economy reforms, although alignment between domestic policies and those relating to European Integration remains weak.⁴

3. Steady economic progress over the past decade allowed Kosovo to transition to upper-middle-income status in 2018. Kosovo has successfully transitioned away from a growth model based on high dependence on foreign aid inflows to a steady expansion in consumption and investment, with a strong impetus from diaspora inflows, public investment in infrastructure, and financial deepening. Gross Domestic Product (GDP) growth averaged 4.6 percent between 2010 and 2019.⁵ After contracting by 5.3 percent in 2020 due to the COVID-19 pandemic, the economy rebounded quickly, reaching a record of almost 11 percent in 2021. In 2022, GDP growth had moderated to an estimated 3.1 percent. While medium-term growth is expected to be stable, uncertainties related to Russia's invasion of Ukraine, including on international food and energy prices, entail downside risks.

4. However, overall economic performance has not yet resulted in strong poverty reduction. GDP growth in the decade prior to the pandemic translated into a nearly 50 percent increase in per capita income and a 35 percent reduction in poverty.⁶ After a spike in the poverty rate⁷ in 2020 (32.4 percent), poverty fell in 2021 (26.4 percent) and is expected to continue declining over the medium-term. Yet Kosovo remains one of the poorest countries in the Western Balkans.⁸ Low labor force participation and employment, especially among women, are constraints to poverty reduction, and Kosovo has the lowest labor force participation rate in the region, at just 39.3 percent in 2021.

5. Gender equality is critical to the Government's social and economic development agenda, yet inequalities persist, and gender-based violence (GBV) remains a challenge. Gender inequalities in decision-making and leadership, access to justice and education, and labor market participation present significant challenges. However, the most extreme

¹ World Bank Group (WBG) (April 2023). FY23-FY27 Kosovo Country Partnership Framework (Report Number 180809-XK, discussed by the Board of Executive Directors on May 9, 2023). <https://documents1.worldbank.org/curated/en/099041723104545397/pdf/BOSIB0a3dc36ae0c40be3c058429f10a40d.pdf>

² Four different coalition governments were elected between 2017 and 2021.

³ Balkan Public Barometer Database (December 2023). Perceptions on Public Institutions and Services, Trust in Government. <https://www.rcc.int/balkanbarometer/results/2/>

⁴ Organisation for Economic Co-Operation and Development (November 2021). The Principles of Public Administration: Kosovo Monitoring Report. <https://www.sigmaweb.org/publications/Monitoring-Report-2021-Kosovo.pdf>

⁵ WBG (January 2022). Republic of Kosovo, Systematic Country Diagnostic Update 2022 (Report Number 169605-XK) and author's calculations. <https://elibrary.worldbank.org/doi/epdf/10.1596/37486>

⁶ Supra, WBG (April 2023).

⁷ Percent of people living on less than US\$6.85 per day, 2017 purchasing power parity.

⁸ WBG (Fall 2023). Toward Sustainable Growth. Western Balkans Regular Economic Report Number 24.

<https://documents1.worldbank.org/curated/en/099101623051741490/pdf/P50064801939bc0a00a0d2077a3883b52c9.pdf>



manifestation of gender inequality is the prevalence of GBV, with 54 percent of women reporting to have experienced psychological, physical or sexual violence at the hands of an intimate partner since the age of 15.⁹ During the first months of the pandemic, the Ministry of Justice reported a 17 percent increase in GBV reports.¹⁰ The Government has shown a commitment to improve policies and response to GBV,¹¹ yet progress in preventing GBV has been slow and more funding for related activities is needed to meet the needs of those who have experienced GBV.

6. Kosovo also faces environmental and climate change challenges that pose risks to the sustainability and inclusiveness of growth. Mismanagement of natural resources, especially water and land, coupled with overreliance on fossil fuels hamper the sustainability of the economy, increase Kosovo's exposure to natural disasters, and affect the health of the population. Like the rest of the globe, Kosovo is prone to increasing temperatures. Beyond an overall average increase in temperature, the main impact of climate change in Kosovo will be the decrease in rain during the summer, resulting in more frequent droughts and forest fires, and an increase in rain during the winter, resulting in more frequent spring flooding. Overall Kosovo has greater water scarcity than its Western Balkans neighbors and has limited resources for water development and storage. In addition, existing water resources are unevenly distributed.¹² Limited water resources, dilapidated water and sanitation infrastructure, and weak waste management systems, combined with growing urbanization, intensive mining, and domestic energy demands are already putting stress on Kosovo's main water basin. As highlighted in Kosovo's Water Security Outlook, in the next 20 years, all of Kosovo's basins will be water-stressed.¹³ On top of these challenges, Kosovo's location in a seismically active area increases the likelihood of catastrophic earthquakes.

7. The Government's reform agenda takes a multi-sectoral approach to strengthening economic growth and ensuring a sustainable and inclusive recovery from the COVID-19 pandemic. Over the short-term, the Government Program (2021-2025) prioritizes: (i) minimizing the public health impact of the pandemic; and (ii) alleviating its economic and social consequences.¹⁴ Over the medium-term, the National Development Strategy (2021-2030) outlines national priorities, including: (i) sustainable economic development; (ii) equitable human development; (iii) safety and rule of law; and (iv) good governance.¹⁵

B. Sectoral and Institutional Context

8. Despite improvements in life expectancy in recent years, Kosovo lags behind other Western Balkans countries in key health outcomes. At 7.5 per 1,000 live births, Kosovo has the highest neonatal mortality in the Western Balkans and one of the highest in the Europe and Central Asia (ECA) region, after Azerbaijan (9.5).¹⁶ A similar situation is observed for under-five mortality, where Kosovo scores the fourth highest rate in ECA.¹⁷

9. Kosovo's poor health outcomes highlight the challenges in access to and quality of healthcare services, while the COVID-19 pandemic revealed several structural weaknesses and underscored the importance of investing in health to improve resilience to future shocks. A large share of the population lacks routine access to medical services (blood pressure monitoring, consistent antenatal care, etc.), and noncommunicable diseases (NCDs), despite the fact that legal

⁹ Organization for Security and Cooperation in Europe (November 2019). Survey on Well-being and Safety of Women in Kosovo.

<https://www.osce.org/files/f/documents/d/c/439781.pdf>

¹⁰ United Nations Population Fund (April 2020). GBV Spikes Amid Pandemic. <https://www.unfpa.org/news/gender-based-violence-spikes-amid-pandemic-shelters-need-support>

¹¹ The Republic of Kosovo adopted the National Strategy on Protection Against Domestic Violence and Violence Against Women (2022-2026) in February 2022.

¹² WBG (June 2018). Kosovo Water Security Outlook. <https://documents1.worldbank.org/curated/en/496071548849630510/Water-Security-Outlook-for-Kosovo.pdf>

¹³ Supra, WBG (June 2018).

¹⁴ Republic of Kosovo (May 2021). Program of the Government of the Republic of Kosovo (2021-2025). <https://kryeministri.rks-gov.net/wp-content/uploads/2022/04/Programi-i-Qeverise-se-Kosoves-2021-2025.pdf>

¹⁵ Republic of Kosovo (2021). National Development Strategy (2021-2030). <https://kryeministri.rks-gov.net/en/national-development-strategy-2030/>

¹⁶ WBG (2021). World Development Indicators. <https://databank.worldbank.org/source/world-development-indicators#>

¹⁷ Kosovo has the third highest infant mortality (9.1 per 1,000 live births, 2021) in ECA after Azerbaijan (16.6) and Armenia (9.5), and the fourth highest under-five mortality (10 per 1,000 live births, 2021) after Azerbaijan (18.6), Armenia (10.7), and Kazakhstan (10.3). WBG (2021). World Development Indicators.



framework allows for free public healthcare, and this affects a significant number of adults: about 21.6 percent of adults reported having a chronic disease in 2017. For the 32 municipalities for which data are available, only three meet the Government’s target to have one physician per 1,000 inhabitants and only 16 municipalities meet the target of two nurses per 1,000 inhabitants. In hospitals, inpatient beds per 100,000 inhabitants (226 in 2019) are significantly below neighboring countries and the EU average of 532, although the low bed-occupancy rate (around 53 percent) suggests that there are existing quality issues, and not a pressing need to increase the number of beds. In addition, Kosovo’s lack of qualified staff is compounded by the dilapidated state of medical facilities, absence of a unified health information system (HIS) to track and follow up on treatment of patients, and inadequate waste management. Shortage of drugs is the top reason for population’s dissatisfaction with services in the public health sector, cited by 33 percent of respondents in the 2017 Household Budget Survey¹⁸. In this context, many Kosovars seek healthcare services in neighboring countries, even for routine check-ups.

10. While Kosovo enacted a Law on Health Insurance in 2014 giving all citizens the right and obligation to carry mandatory health insurance, the law lacked regulation of contracting mechanisms, among many other gaps, and is thus yet to be implemented. Government spending on health remains low. Total current spending on health, both in absolute value and as a share of GDP, is the lowest in the region. This is driven by a combination of relatively modest Gross National Income per capita and low priority of health in general government expenditure (GGE). Although the share of out-of-pocket (OOP) spending in total health expenditure at 38 percent is on par with most other countries in the Western Balkans, it exceeds the acceptable level to ensure financial protection for the population (below 20 percent).

Table 1. Key socio-economic, health, and health spending indicators (2019)

Country	Kosovo	Albania	BiH	Montenegro	North	
					Macedonia	Serbia
Population (million)	1.8	2.9	3.4	0.6	2.1	7.0
Population ages 65 and above (% of total population)	9.4	15.4	17.2	15.6	14.3	20.5
GNI per capita, Atlas method (current US\$)	4,640	5,230	6,160	9,140	5,890	7,040
Life expectancy at birth (years)	79.0	79.3	77.2	76.7	76.6	75.9
Neonatal mortality (per 1,000 live births)	8.3	7.1	4.3	1.2	4.5	3.6
Under 5 mortality (per 1,000 live births)	11.2	9.4	5.9	2.7	6.8	5.7
Current health expenditure per capita (current US\$)	226	275	544	732	421	641
Current health expenditure (% of GDP)	5.1	5.2	9.0	8.3	7.1	8.7
Domestic GGHE (% of GDP)	3.0	2.9	6.2	5.1	4.3	5.1
Domestic GGHE (% of GGE)	10.6	9.8	15.4	11.5	13.6	12.0
OOP expenditure (% of current health expenditure)	38.0		29.4	38.6	39.1	37.1

Source: WBG. World Development Indicators (except Kosovo), 2023. Data on current health spending per capita for Albania are from 2018. BiH: Bosnia and Herzegovina; GGHE: General Government Health Expenditure.

11. Low quality of care (QoC) is one of the most critical constraints to universal health coverage in Kosovo. QoC consists of: (i) structure (the manner in which care is delivered, including facilities, equipment, and human resources); (ii) process (the interactions between patients and providers, including diagnoses, treatment, preventive care, and patient education); and (iii) outcomes (the effects of health care on health status of patients and population).¹⁹ In terms of structure, outpatient drugs at the primary health care (PHC) level are limited in quantity and variety, and hospital equipment is often outdated, defective, or out of service. In many cases, basic infrastructure is missing or of low quality, including building structures, air conditioning, patient bathrooms, and specifically lack of physical access for differently

¹⁸ Kosovo Household Based Survey. 2017. Kosovo Agency of Statistics. <https://ask.rks-gov.net/>

¹⁹ Donabedian, A. (2005). Evaluating the Quality of Medical Care, *The Milbank Quarterly*, 83(4):691-729. <https://www.med.unc.edu/ihqi/wp-content/uploads/sites/463/2021/01/A-Model-for-Measuring-Quality-Care-NHS-Improvement-brief.pdf>



abled persons.²⁰ The current handling of healthcare waste (HCW) poses a major challenge and an environmental threat to Kosovo. Infrastructure for healthcare waste management (HCWM) needs attention, since treatment equipment of infectious waste in some regional hospitals is over ten years old and is in disrepair, posing a threat to patients and providers. In terms of process, significant gaps exist in the practice of evidence-based medicine and integrated patient management. The use of clinical protocols and guidelines to ensure standardization and promote high-quality care is limited, and there is a lack of effective coordination between PHC centers and hospitals or between family medicine doctors and specialists. As a result of the suboptimal structure and process of care, patient health outcomes are often compromised. For example, over 90 percent of the new lung cancer cases are diagnosed at advanced and inoperable stages, a rate that is considerably higher than in other countries in the region (38 percent in Lithuania, 40 percent in Estonia, and 30 percent in Slovenia).²¹ One notable challenge in Kosovo is the lack of evidence-based NCD registries and an organized cancer screening program.

12. The foundation of Kosovo's health system needs to be strengthened to improve the overall QoC. As a young nation which experienced considerable political and institutional instability until very recently, Kosovo's health system lacks a strong foundation for delivering high-quality care in critical areas, including service delivery, health financing, public health and pandemic prevention and response (PPR), with availability of information for stewardship and governance being a cross-cutting constraint. Kosovo's challenges related to these key health-system building blocks are elaborated further below.

Service Delivery

13. In addition to inadequate supplies and low quality of infrastructure, various challenges in institutional capacity and governance exist. These manifest in: (i) the lack of a strategy for improving QoC; (ii) insufficient quality standards (clinical guidelines, protocols, pathways, checklists, etc.) to guide clinical practices; (iii) insufficient institutional arrangements for quality at different levels of the system, including an understaffed Quality Division in the Ministry of Health (MoH), suboptimal arrangements for development of quality standards, a lack of quality coordination mechanisms at hospital level, ineffective roles of the quality coordinators for PHC, etc.; (iv) the absence of systematic quality monitoring at all levels of care; (v) the lack of a good decision support system for practitioners, such as electronic care pathways; and (vi) limited capacity of health workers. In addition, the MoH lacks sufficient inspection capacity to enforce the basic requirements for patient safety. The Health Inspectorate of the MoH, tasked with inspecting both public and private healthcare facilities, is currently understaffed, with only ten inspectors. Coupled with lack of standardized inspection practices and resources, this significantly challenges the MoH's ability to conduct inspections. Moreover, citizen engagement is limited and, as a result, there are low population expectations and demand for quality services.

Health Financing

14. Kosovo has not yet developed a mechanism for strategic purchasing of quality health services. As noted above, the Health Insurance Law was passed in 2014 and a Health Insurance Fund (HIF) was subsequently established in 2017. However, the HIF has yet to begin contracting with health institutions, and, as such, is missing the opportunity of using strategic purchasing to ensure accountability for important quality standards. Service providers are paid mainly through a historical line-item-based budget, a large share of which covers salaries, leaving little incentive for improving quality and efficiency, although several initiatives to incentivize quality improvement exist, such as through the health grant for PHC. An explicit basic benefit package is yet to be defined to guarantee services to the population. An outpatient drug benefit package (ODBPs) was drafted under the Kosovo Health Project (P147402), but its rollout has been challenging due to the lack of a legal basis for its implementation under the existing Health Insurance Law. This further exacerbates the existing shortage of government-subsidized medicines compared to real needs.

²⁰ European Investment Bank (2019) Upgrading the Physical Infrastructure of Secondary and Tertiary Healthcare Institutions: Feasibility Study.

²¹ German Agency for International Cooperation (GIZ) and Kosovo Ministry of Health (MoH) (2022). Support to Kosovo institutions in developing a National HCWM Plan in line with the Kosovo Integrated Waste Management Strategy. Recommendation Report - Prioritization of Interventions



Public Health and PPR

15. Antimicrobial resistance (AMR) and infection prevention and control (IPC) are critical issues impacting patient treatment outcomes. Based on the World Health Organization (WHO) Joint External Evaluation methodology, Kosovo scored a one in AMR and a two in IPC (out of five). Fifty eight percent of invasive *Staphylococcus aureus* isolates in Kosovo were multi-resistant *Staphylococcus aureus*, compared to 14.4 percent in EU countries. At the hospital level, the use of antibiotics in children is almost 1.6 times higher than the EU average (57 percent compared to 36 percent). In European hospitals, lower respiratory tract infections are treated with ceftriaxone in only 8.2 percent of cases, while in Kosovo it is used in an estimated 82.3 percent of cases.²² Increases in temperature and changes in humidity and precipitation may increase the spread of AMR and healthcare-associated infections (HAI), with climate change contributing to more frequent and severe extreme heat and flood events likely resulting in increased antimicrobial drug use in humans and animals.^{23,24} In addition to creating unnecessary costs, inappropriate antibiotic use leads to longer hospital stays and poorer health outcomes. Beyond the lack of guidelines, Kosovo's quality assurance mechanisms related to antibiotic use are not properly functioning and necessary information is not being collected and/or shared in a timely manner to facilitate effective decision making. In the area of IPC, critical shortcomings are reported regarding existing practice at the facility level. Specifically, the hospital infection control committees mostly exist on paper only; there are no adopted Standard Operating Procedures for prevention measures in hospitals; HAI were not detected at all, or very rarely in many instances; and the hospital infrastructure is not appropriate for preventing cross-infection from conventional communicable disease cases, whether between patients or to staff, which increases the risk of patients acquiring HAI.²⁵ Strategies for health promotion in this area are in place, although more financing is needed to fully implement them.

16. Weak HCWM poses a major public health threat. Only about 74 percent of the total generated healthcare waste in 2021 was safely treated in licensed installations. While the final destinations for the remaining 26 percent were not clearly established, there is a high likelihood that the infectious and sharp waste ended up in landfills for municipal solid waste, posing serious health and environmental concerns.²⁶ Kosovo's weak HCWM is due to: (i) a lack of adherence to waste management plans in the health care facilities; (ii) a lack of designated and qualified staff responsible for HCWM; and (iii) weak monitoring and evaluation in HCWM to inform decision making. Again, a strategy for improving HCWM has been developed and approved, but substantial funding is needed to make progress in its implementation.

Health Information System

17. Kosovo is in the early stage of developing a fully functional integrated health information system (IHIS), which is essential to enable improvements in QoC, quality measurement, and provision of feedback. The PHC level has a basic health information system (BHIS), which started out with minimal functionality to register patients and further evolved (with support from the Kosovo Health Project (P147402)) to include other functions, such as tracking patient medical history and supporting the key PHC workflows. Currently, only some legacy systems (such as e-prescription, HIF Information System, pharmaceutical stock management system, surveillance system and early warning system) and BHIS communicate with each other. The existing Laboratory Information Systems (LIS) at the National Institute of Public Health (NIPH) and a few other existing systems currently do not communicate with BHIS and each other. Health care providers do not produce data on diagnoses and procedures connected with patient visits. The main source of health data is the

²² Raka, L., et al., Antimicrobial Resistance and Limited Resources: A Kosovo Case, Kosovo Academy of Sciences.

²³ How Antimicrobial Resistance Is Linked to Climate Change: An Overview of Two Intertwined Global Challenges Roberta Magnano San Lio, Int J Environ Res Public Health. 2023 Feb; 20(3): 1681. Published online 2023 Jan 17. doi: 10.3390/ijerph20031681 PMID:MC9914631 PMID: 36767043

²⁴ Meinen A, Tomczyk S, Wiegand FN, Abu Sin M, Eckmanns T, Haller S. Antimicrobial resistance in Germany and Europe - A systematic review on the increasing threat accelerated by climate change. J Health Monit. 2023 Jun 1;8(Suppl 3):93-108. doi: 10.25646/11404. PMID: 37342428; PMCID: PMC10278373.

²⁵ European Center for Disease Prevention and Control (2018). Kosovo. Assessment of capacity development, health governance, surveillance, preparedness and response in the field of communicable diseases

²⁶ Republic of Kosovo (August 2014). Strategy of the Republic of Kosovo on Waste Management (2013-2022). <https://kryeministri.rks-gov.net/wp-content/uploads/2022/07/STRATEGY-OF-THE-REPUBLIC-OF-KOSOVO-on-WASTE-MANAGEMENT.pdf>



annual statistics, which are at the aggregate level and are not updated in real time. Furthermore, the quality of health statistics leaves much room for improvement, because even the most basic statistic – cause of death – is not available for some 20 percent of all registered deaths. The lack of reliable data hampers the ability of the system to measure QoC, support providers in improving quality and coordinating patient management, and hold providers accountable for their performance. It also limits the capacity of the MoH to exercise its stewardship function to ensure quality services for the population.

18. Progress has been made in developing legal frameworks and other foundational conditions for strengthening Kosovo’s health system, with the aim of delivering quality services to the population. Kosovo is amending the Law on Health and updating the Health Insurance Law. In addition, a Health Sector Strategy for the period 2024-2030 is under preparation and prioritizes improving access to and quality of health services as two of its strategic objectives. It specifically envisages the establishment of a QoC technical support team under the NIPH and a specialized monitoring division under the MoH to enhance quality oversight and management within the healthcare system. In addition, development of comprehensive quality framework for healthcare services is currently being discussed with the support from the Swiss Agency for Development and Cooperation (SDC). Between 2018 and 2023, 27 clinical guidelines and six protocols have been developed and adopted, with an additional 22 guidelines and five protocols being in various stages of development and approval. Another 24 new guidelines and 12 protocols are planned for 2024. The MoH has approved the new Administrative Instruction on Drafting Clinical Guidelines and Protocols which will, among other things: (i) revise the methodology for preparation of guidelines and protocols so that not all working group members have to be trained on the methodology; (ii) ensure that the same working group members who have drafted the guidelines will also be in charge of drafting protocols; and (iii) standardize the approach for guideline preparation. The MoH is actively working on the expansion of its workforce by hiring additional inspectors, aiming to enhance the capacity and effectiveness of healthcare facility oversight. A law on pricing of pharmaceutical products was recently approved by the Parliament.²⁷ The MoH has also approved the Law and Action Plan of the National Program on Communicable Diseases (2023) and an Action Plan for HCWM (2023) and has finalized an eHealth feasibility study with a proposed overall architecture for the entire IHIS. All these advancements will inform concrete interventions to build the foundation for a strong health system designed to provide high-quality care.

C. Relevance to Higher Level Objectives

19. The project seeks to address the institutional constraints to delivering quality services as identified in the 2022 update to the Systematic Country Diagnostic (SCD)²⁸ and is well aligned with the Country Partnership Framework for FY23-27.²⁹ By focusing on improving QoC, the project is responsive to Policy Pathway 3 of the SCD, investing in human capital and increasing inclusion. Project activities also contribute to the cross-cutting objective of resilience by strengthening the capacity of Kosovo in PPR. Further, the project responds closely to the evolving World Bank mission and vision as set out in the Evolution Roadmap, including, providing financial and analytical support to middle-income countries for reducing poverty and addressing global challenges, such as climate change and pandemic preparedness and resilience. This is also aligned with the World Bank’s Global Challenge Program approach, specifically with the thematic focus on Enhanced Health Emergency Prevention, Preparedness and Response³⁰ through strengthening health systems at country level. Moreover, the explicit attention to gender and climate change matches the CPF objectives.

20. The project addresses key national priorities in health and is aligned with both the Government Program (2021-2025) and the National Development Strategy (2021-2030). Project activities have been informed by the health sector

²⁷ Law No 08/L-220 on Prices for Medical Products dated August 3, 2023.

²⁸ Supra, WBG (January 2022).

²⁹ Supra, WBG (April 2023).

³⁰ World Bank. 2023b. *Ending Poverty on a Livable Planet: Report to Governors on World Bank Evolution*. DC2023-0004, World Bank.

<https://www.devcommittee.org/content/dam/sites/devcommittee/doc/documents/2023/Final%20Updated%20Evolution%20Paper%20DC2023-0003.pdf>



priorities highlighted in the National Development Strategy, including with respect to health infrastructure, health workforce, digital health, and public health insurance. By supporting on-going health sector reforms and building institutional capacity and governance mechanisms to implement the QoC reform, the project directly supports the goals of the Strategy, particularly to invest in health services and provide public health insurance to improve the quality of life of Kosovo's citizens. The project's focus on digitalization in the health sector also supports the Strategy's goals of improving transparency and evidence-based policy making. With the emphasis on expanding provider competencies, including for the provision of and referral for GBV services, the project is also supporting the Kosovo's Program for Gender Equality (2020-2024)³¹ and the National Strategy on Protection Against Domestic Violence and Violence Against Women (2022-2026).³²

21. The project is consistent with Kosovo's Climate Change Strategy (2019-2028),³³ which identified public health as one of the eight key areas for climate adaptation. Although Kosovo is not a party to the United Nations Framework Convention on Climate Change and its subsequent Paris Agreement, it is in the process of developing its first inclusive and voluntary Nationally Determined Contribution (NDC) and has ambitious goals to phase out coal and boost use of renewables. Kosovo's signature of the Sofia Declaration (2020) signaled its commitment to decarbonization by 2050.³⁴ In addition, Kosovo aims to reduce greenhouse gas emissions by up to 49 percent by 2030 compared to 2016 levels.³⁵ The project contributes to these goals by supporting the resilience of the health system to climate change hazards and reducing greenhouse gas emissions of the built infrastructure in the health sector. In addition, the health sector increasing its institutional capacity for public health and PPR are important interventions that will contribute to reducing climate change vulnerability of the population by ensuring proactive prevention of and timely identification and treatment of diseases, including those that are projected to increase in Kosovo due to climate-related changes, such as respiratory diseases, as well as food- and water-borne diseases.

II. PROJECT DESCRIPTION

A. Project Development Objective

22. The Project Development Objective (PDO) is to strengthen institutional capacity and governance for quality of care in the Kosovo health system.

23. To track the achievement of the PDO, three key indicators will be utilized, as outlined below:

- Ratings on a five-point scale for indicators 8 (IPC in human health care) and 9 (optimizing antimicrobial use in human health) in the Central Asia and European Surveillance of AMR (CAESAR) Network Assessment (number) (*reflecting institutional capacity and governance for QoC in the area of public health and PPR*);
- PHC facilities and hospitals reporting on a set of nationally adopted QoC indicators in the public domain (percentage) (*reflecting governance for QoC in service delivery*); and
- Hospital outpatient specialist visits with electronic referrals (percentage) (*reflecting the strengthened institutional capacity for QoC with a particular focus on patient coordination*).

³¹ Republic of Kosovo (June 2020). Kosovo Program for Gender Equality (2020-2024). <https://abgj.rks-gov.net/assets/cms/uploads/files/AGE%20Kosovo%20Program%20for%20Gender%20Equality%202020-2024.pdf>

³² Republic of Kosovo (January 2022). Nation Strategy On Protection Against Domestic Violence and Violence Against Women (2022-2026). <https://kryeministri.rks-gov.net/wp-content/uploads/2022/08/ENG-Strategjia-Kombetare-per-Mbrojtje-nga-Dhuna-ne-Familje-dhe-Dhuna-ndaj-Grave-2022-2026.pdf>

³³ Republic of Kosovo (2018). Climate Change Strategy (2019-2028). https://konsultimet.rks-gov.net/Storage/Consultations/14-13-59-04102018/Climate%20Change%20Strategy%20and%20Action%20Plan_sep_2018.pdf

³⁴ Regional Cooperation Council (November 2020). Sofia Declaration on the Green Agenda for the Western Balkans. <https://www.rcc.int/docs/546/sofia-declaration-on-the-green-agenda-for-the-western-balkans-rn>

³⁵ NDC Partnership (2023). COP28: Kosovo's first inclusive and voluntary NDC. <https://www.youtube.com/watch?v=8xll1xQw5Qg>



B. Project Components

24. Project objectives will be achieved by a mutually reinforcing set of interventions, focusing on strengthening institutional capacity and governance for quality, including related to AMR, IPC and HCWM, as well as improving overall service delivery and health financing. The project will also support the development of the IHIS as a critical enabler of QoC. Service delivery interventions will center on enhancing governance and institutional mechanisms for QoC monitoring, capacity building for PHC professionals and quality coordinators for utilization of clinical guidelines, and support to the Health Inspectorate. Health financing interventions will help develop strategic purchasing capacity for high-quality services. Developing an IHIS will be essential to all other aspects of the project since they all rely on improved collection and sharing of health information. The project has three components, described below.

25. Component 1: Strengthening key health system building blocks for quality of care (EUR 6.46 million; US\$ 6.95 million equivalent). This component will support aspects of public health/PPR, service delivery, and health financing (strategic purchasing), that will help unblock the bottlenecks in structural and process aspects of QoC.

26. Subcomponent 1.1: Improving service delivery (EUR 1.31 million; US\$ 1.41 million equivalent). This subcomponent is aligned with the strategic objectives of the forthcoming Health Sector Strategy for the period 2024-2030 and builds on the recommendations of the World Bank's recent report highlighting the quality aspect of NCD management in Kosovo.³⁶ It focuses on enhancement of care processes through several high-impact initiatives and will include two groups of activities:

- **Strengthening governance for quality of care**, including: (i) supporting the functionalization of the QoC technical teams within the NIPH, Kosovo Hospital and University Clinical Services (KHUCS), and MoH through technical support on establishing governance structures, roles and responsibilities, development of relevant monitoring and reporting tools, and staff capacity building to enhance quality oversight within the health system; (ii) supporting the Annual Regional and National Health Forums, which serve as platforms for discussion, information sharing, and decision-making related to health policies, strategies, and practices, as well as to foster formalized citizen engagement, empowerment, and ignite the demand for high-quality health services; and (iii) strengthening the Health Inspectorate through training, provision of information technology (IT) support (equipment, supplies, software solutions, and tablets for e-inspections), and development and revision of safety and quality standards, including, but not limited to, IPC measures, safe handling of medical equipment, and emergency response protocols, including response to climate-related events.
- **Strengthening institutional capacity for quality of care**, including: (i) strengthening institutional processes for the development, evaluation and adoption of clinical guidelines, including defining the models for incentivizing and motivating working groups, ensuring active participation and commitment from healthcare professionals; (ii) development of electronic care pathways and protocols (including integration of climate-resilient measures) to enable their integration into the BHIS, facilitating and providing data for monitoring the use of clinical guidelines;³⁷ (iii) training of providers on clinical guidelines/protocols/clinical care pathways, clinical audits, and best quality assurance/quality management (QA/QM) practices; and (iv) development of quality indicators,³⁸ clinical audit and feedback manual for quality coordinators. These activities will also strengthen the capacity of PHC quality coordinators for monitoring the QoC, selecting clinical audit topics, monitoring anticipated increases in AMR due to the link to climate change and conducting clinical audits, and providing feedback to health professionals.

³⁶ WBG (June 2023). The State of NCDs in Kosovo. <https://elibrary.worldbank.org/doi/abs/10.1596/39935>

³⁷ The development of electronic pathways and protocols will begin with a primary focus on PHC, but could be expanded to hospital care following the development of the HMIS (Component 2).

³⁸ The development of indicators will initially concentrate on PHC, aligning with established care pathways, and will subsequently extend to the hospital level as hospital electronic care pathways are developed and implemented.



27. Importantly, given the pervasiveness of GBV, this subcomponent will also support trainings for PHC workers in topics related to all different types of GBV, particularly intimate partner violence and psycho-social health support. Specifically, healthcare workers in selected PHCs will be trained as first points of contact in the healthcare system to enhance their knowledge in identifying GBV cases, appropriately handling confidentiality, and referring survivors for further services, using a survivor-centered approach and WHO guidelines.³⁹ Special attention will be given to management of cases of GBV, including clinical management of rape and psychological first aid, including safety planning. This activity builds on the work under the ongoing Kosovo Emergency COVID-19 Response Project (P173819). As such, the training program has already been accredited by the Chambers of Doctors and Nurses and the Training of Trainers has already been completed, allowing for more rapid expansion of training to additional providers at more PHC facilities. The training modules include such topics as psychological first aid, culturally sensitive communication techniques, and understanding and changing social and gender norms, as well as the psychological impact of GBV on healthcare providers, themselves.⁴⁰ Training of healthcare workers will help strengthen both the GBV referral system and expand provision of GBV-appropriate care. The project will measure progress through an increase in health workers trained to care for and refer survivors of GBV.

28. Subcomponent 1.2: Developing and implementing strategic purchasing for quality (EUR 0.30 million; US\$ 0.32 million equivalent). This subcomponent will support the development and implementation of key strategic purchasing elements, which are not in place in Kosovo but are critical for both structural and process aspects of quality care. Given the uncertainty in the timing of adoption of the revised Health Insurance Law, the subcomponent will focus on a small number of activities, that can begin prior to adoption of the Law. Specifically, the project will support: (i) piloting the ODBP;⁴¹ and (ii) developing and implementing case-based payment for KHUCS, starting with treatment abroad, and capitation-based performance payment for PHC. The project will also support the implementation of the Law on Pricing of Medicinal Products,⁴² which was approved in 2023, through reference pricing bylaws and capacity building.

29. Subcomponent 1.3: Strengthening institutional capacity for public health and Pandemic Preparedness and Response (EUR 4.85 million; US\$ 5.22 million equivalent). This subcomponent will build on activities carried out under the Kosovo Emergency COVID-19 Response Project (P173819) in the areas of PPR. It will support key areas of the Action Plan of the National Program on Communicable Diseases (2022) and the Action Plan for HCWM (2023). Two groups of activities are anticipated, namely:

- **Activities to reduce AMR and strengthen IPC**, including: (a) energy-efficient IPC equipment for health facilities, equipment, consumables, and test kits for public health laboratories to detect new cases of highly resistant bacteria, including those thought to be influenced by climate-driven temperature increases;⁴³ (b) supplies for AMR and HAI surveillance, including costs for proficiency-testing samples or panels; (c) training of healthcare providers on AMR awareness and IPC across all levels of care, which will include trainings on identifying and treating/providing counseling on climate-related diseases, as well as treatment and counselling options for sexually transmitted diseases

³⁹ GBV training will be guided by the following principles: (i) do no harm; (ii) adopt a survivor-centered lens; (iii) build on the strength and resilience of communities; (iv) adopt an intersectional approach; (v) strengthen existing systems, and (vi) be evidence-based. Training will be based on the inter-agency standing committee and WHO and United Nations Population Fund guidelines on addressing GBV in humanitarian settings. <https://www.unfpa.org/minimum-standards> and <https://healthcluster.who.int/our-work/thematic-collaborations/gender-based-violence-in-health-emergencies>

⁴⁰ Healthcare providers are trained in tools to manage their own emotional responses and prevent burnout.

⁴¹ The ODBP defines the list of outpatient drugs that will be included in the insurance benefit package to be managed by the HIF when Social Health Insurance is rolled out. The pilot will introduce a new way of dispensing medicines by having the HIF contract with private pharmacies in addition to public pharmacies at the PHC level. Implementing the pilot will help HIF to develop the capacity to fully implement e-prescription, manage contracts with pharmacies, perform centralized procurement and framework procurement, exercise price control of pharmaceutical products and doctors' prescribing behaviors, and work with the MoH to develop an evidence-based benefit package starting with medicines – all key functions that a typical health insurance fund in peer countries is performing.

⁴² The Law on Pricing of Medicinal Products determines the prices of medicinal products for wholesalers and retailers in the Republic of Kosovo. Up to now, prices of medicines in Kosovo have been unregulated, resulting in significantly higher price than in neighboring countries. Among others, the Law sets maximum allowed prices of all prescription medicines, regardless of whether they are paid for by the state or not by benchmarking prices in selected countries in the region.

⁴³ Meinen A, Tomczyk S, Wiegand FN, Abu Sin M, Eckmanns T, Haller S. Antimicrobial resistance in Germany and Europe - A systematic review on the increasing threat accelerated by climate change. *J Health Monit.* 2023 Jun 1;8(Suppl 3):93-108. doi: 10.25646/11404. PMID: 37342428; PMCID: PMC10278373.



and physical injuries for GBV survivors; (d) expert consultancy, workshops, printing and distribution of AMR guidelines, and equipment and supplies for the Antimicrobial Stewardship Program in hospitals.⁴⁴

- **Activities to support HCWM**, including: (a) provision of standardized protective equipment and medical waste collection supplies and equipment; (b) construction/adaptation of safe storage spaces (warehouses) for infectious and sharp waste; (c) construction/renovation of follow-up infrastructure for treatment of medical waste; (d) replacement of outdated equipment (autoclaves) for medical waste treatment; (e) procurement of vehicles for transporting medical waste; (f) rehabilitation of existing central warehouse to add space for pharmaceutical waste, including design and monitoring of works; and (g) training in HCWM (to be combined with AMR/IPC training).

30. It is expected that the specific investments in this sub-component will be complemented by targeted technical assistance (TA) from a number of partners, including the European Center for Disease Control (AMR in the veterinary sector and environment), WHO (standard operating procedures for HCWM), the International Center for Antimicrobial Resistance Solutions (Antimicrobial Stewardship Program in PHC), the Robert Koch Institute (capacity building in sequencing at AMR reference laboratory at NIPH), and others. Building on the support of other development partners, the TA financed by the project will be limited to focus on specific activities required for the achievement of the PDO. The activities for this subcomponent will address well-documented deficiencies in the QoC related to public health that directly affect clinical patient care, thereby contributing to the achievement of the PDO.

31. Component 2: Developing an Integrated Health Information System (EUR 11.35 million; US\$ 12.2 million equivalent). This component will support the design, development and implementation of an integrated digital health ecosystem that is critical for the functioning of the entire health system. The foundational and key strategic IHIS building blocks will set the digitized health data environment to support health service delivery and decision making. This activity is informed by the “Kosovo eHealth Feasibility Study,” which was completed under the Kosovo Emergency COVID-19 Response Project (P173819). The planned system will include all public health institutions at all levels of care and will allow for the seamless transmission and sharing of health information among all authorized individuals. Based on globally recognized best practices⁴⁵ and the experience with previous health information systems development in Kosovo,⁴⁶ the approach will be to not build one monolithic system but rather an ecosystem of cooperating information systems built on common governance, standardization, and technical foundational building blocks. Such a system will also require robust patient confidentiality and data privacy protocols to ensure that only authorized users can access patient data. Once such protocols are in place, it will be possible to better coordinate patient treatment and care, including in the areas of communicable disease prevention, control, and treatment. Digitization of the health system will build resilience to climate risks by speeding up access to vital health records in times of need whilst simultaneously reducing the risk that analog (paper) records will be lost or destroyed during floods. This, along with the enhanced abilities of digital systems to analyze data and offer real time surveillance, will enable greater access to health services during climate events.

32. Subcomponent 2.1: Establishing foundational building blocks of IHIS (EUR 4.28 million; US\$ 4.6 million equivalent). This subcomponent will support the establishment of critical elements of foundational environment (Enterprise Architecture) for digital health systems implementation, including: (i) the legal framework for transformed health services delivery through digital systems utilization; (ii) the assessment and design of Master Data Management standards and systems, such as foundational registries and common coding and classification systems; (iii) design and implementation of the Health Information Exchange services; and (iv) upgrade of hardware platforms at central locations and in health facilities. In addition, the subcomponent will finance TA and capacity building to strengthen the

⁴⁴ The Antimicrobial Stewardship Program in PHC is being supported by the International Center for Antimicrobial Resistance Solutions.

⁴⁵ For example: WHO Digital Implementation Investment Guide (<https://www.who.int/publications/i/item/9789240010567>); International Telecommunication Union Digital Health Platform Handbook: Building a Digital Information Infrastructure (Infostructure) for Health (https://www.itu.int/pub/D-STR-E_HEALTH.10-2020)

⁴⁶ Project KSV/014 “Health Support Programme in Kosovo” (2009-2017) that aimed at implementation of a comprehensive HIS to be implemented in three phases (2012-2020)



Government's digital health implementation capacity. The MoH will strengthen its key policy and executive digital health governance capabilities, including massive training of health professionals and digital systems' technical administrators.⁴⁷ It will additionally enhance access to health data during climate shocks. In the first two years of the project, the MoH will use TA to guide the implementation until sufficient internal capabilities are developed.

33. Subcomponent 2.2: Digital health support for improvement in quality of care (EUR 0.90 million; US\$ 0.97 million equivalent). Implementation of Component 1 will require finalization of the implementation and upgrade of the BHIS. Currently, the BHIS is not fully utilized in all PHC facilities and with full functionality. This subcomponent will support: (i) rolling out the BHIS to all PHC facilities (including finalization of patient empanelment and zoning); (ii) upgrading the BHIS functions (automatic update of codes from key registries and allowing smart reporting on facility level); and (iii) upgrading the integration with eReferrals system and introduction of eAppointments. The fully implemented and upgraded BHIS will be ready to integrate the electronic clinical guidelines and automatically report quality indicators, as envisaged in Subcomponent 1.2. The rollout of BHIS and the upgrade of the eReferrals system will incorporate energy-efficient standards.

34. Subcomponent 2.3: Implementation of IHIS strategic systems (EUR 6.17 million; US\$ 6.63 million equivalent). The eHealth Feasibility Study envisages full digitalization of the health sector in Kosovo to improve effectiveness and efficiency of service delivery, clinical decision support, health financing, pandemic preparedness and public health functions, supply chain for pharmaceuticals and nutraceuticals, health workforce management, and health system management and policy making. The Government is already investing in the implementation of some of the systems or planning investment in the near future (such as full hardware equipping; central radiology information system, including Picture Archiving and Communication Systems; blood transfusion management system; patient portal; ePrescription; and central electronic health record). The project will complement government's investment by financing the implementation of: (i) Hospital Management Information System (HMIS) for all public general hospitals (regional hospitals); (ii) central LIS; (iii) strengthening NIPH health data analytics capabilities by introducing the data warehouse and improvement of data transfer interfaces and smart analytics (including NCD, cancer and screening registries); (iv) upgrade of early warning and surveillance system; and (v) development of the e-Inspections system. The IHIS strategic systems upgrade will incorporate energy-efficient standards.

35. Component 3: Project Management, Monitoring and Evaluation (EUR 0.79 million; US\$ 0.85 million equivalent). This component will support overall project administration, including project management, fiduciary functions (procurement, financial management (FM)), monitoring and evaluation, environmental and social compliance, and regular monitoring of and reporting on project implementation. The component will finance consulting services, including consultants to staff the Project Coordination Unit (PCU), as well as office equipment, training, audits, filing systems, and operating costs.

C. Project Beneficiaries

36. All Kosovar citizens will benefit from improvements in quality of health services over time. Upgrading critical health infrastructure, developing clinical guidelines and QoC standards, strengthening capacity of health providers, and digitizing health information will improve the structure and process of care, which in turn will lead to better patient outcomes. Citizens will also have the opportunity for meaningful engagement and benefit from the impact of closing the accountability loop through participation in Regional and National Health Forums. Project support for provider training to improve GBV care is also expected to improve quality and use of services for those experiencing GBV.

⁴⁷ For details, please, see the Implementation Arrangements section.



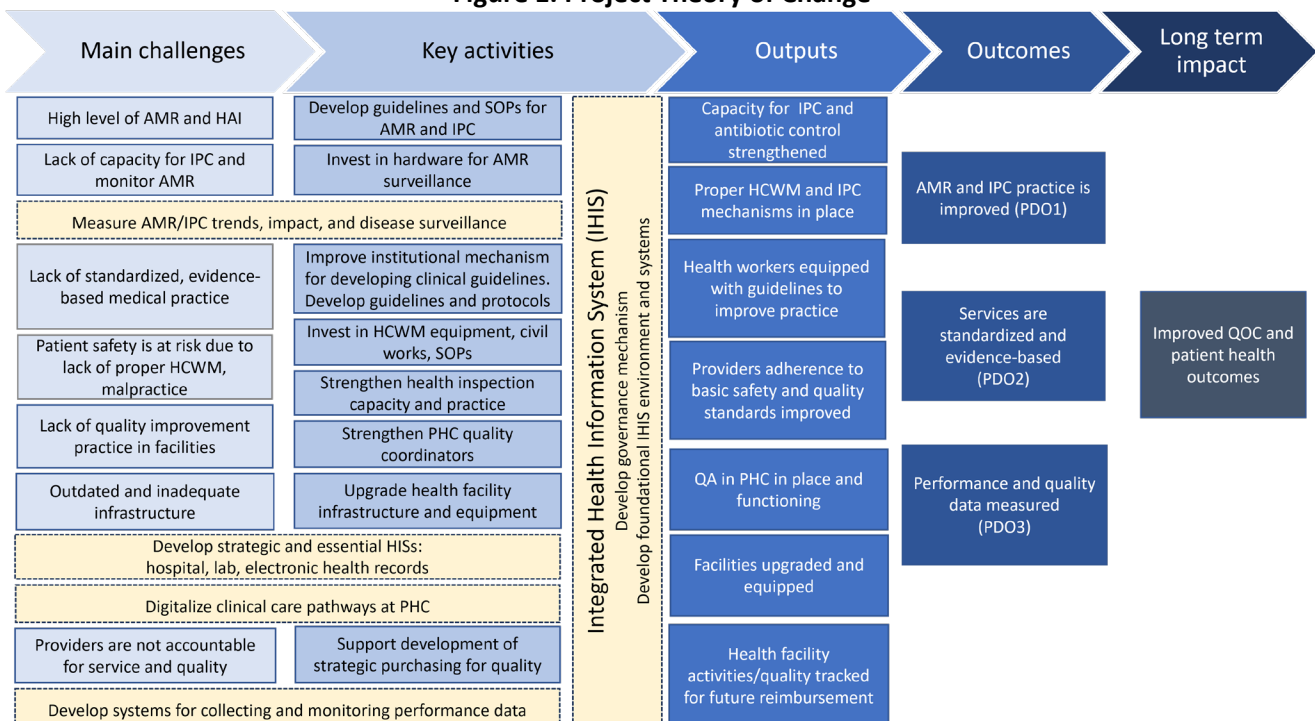
37. Government entities and decision makers will benefit from the expanded digitalization of the health sector. Project support to implement the HMIS and LIS, improve data analytics capabilities, and modernize digital infrastructure will enhance decision making and improve governance. The ability to share data through the implementation of interoperability standards/protocols and use of cloud solutions, among others, will improve opportunities for collaboration and analysis of health information to improve timeliness and effectiveness of decision making.

38. The project will also directly benefit health professionals, especially at the PHC level. Health providers will benefit from opportunities to deepen critical IPC, AMR, and HCWM skills, stay current with newly developed clinical care pathways and quality assurances practices, and upgrade their competence in the use of digital systems through trainings and improved access to state-of-the art equipment, allowing providers to perform a broader range of health services and to be able to identify the links between climate and AMR (particularly extreme heat and flood related), and HCWM vulnerabilities (particularly to flood risks). The rollout of the BHIS to all PHC facilities, improved functionality of the BHIS, and integration of the eReferrals system is also expected to reduce time required to fill out paperwork, thus increasing their productivity and motivation.

D. Results Chain

39. Taken together, activities financed by the project will lead to improved capacity of the health system as a whole. This includes, but is not limited to, improved health outcomes due to reduction in AMR and HAI interventions, including those related to HCWM. The project will also lead to better capacitated health workers who have the facilities, equipment, and quality measurement and improvement tools to provide higher-quality care. All these areas will be supported by improved information systems that will record and share essential health information at both the patient and facility level, allowing real-time monitoring and measurement of the health system (Figure 1).

Figure 1. Project Theory of Change





E. Rationale for Bank Involvement and Role of Partners

40. The World Bank has been a key development partner of the Government of Kosovo in the health sector over the past decade. Through lending operations and technical assistance, the World Bank is recognized as an important partner for its comparative strength in the planning and management of complex health care reforms and transferring new technologies and innovations. It brings relevant experience from extensive regional and global knowledge and is uniquely positioned to support government efforts to improve the effectiveness of the health care system in improving QoC and strengthening the capacity for public health preparedness and response by modernizing critical health infrastructure, building capacity in health providers, and strengthening the BHIS.

41. Project activities complement the efforts of other development partners. Key development partners working in the health sector include SDC, the WHO, the Council of Europe Bank, and GIZ. SDC is supporting efforts to improve QoC and integration with the PHC level in two selected hospitals (Gjakova and Peja). WHO is supporting public health preparedness and response, as well as providing technical support to develop the Standard Operating Procedures for HCWM. The GIZ provides technical assistance related to implementation of the HCWM plan. The Council of Europe Bank and European Investment Bank will finance infrastructure and equipment investments at the hospital level. Project activities will be complementary to existing support by other partners. Specifically, the project strengthens the hospital AMR stewardship program, while AMR activities at the PHC level are being supported by the International Center for AMR Solutions. In addition, project interventions will use WHO's developed Standard Operating Procedures to further expand on HCWM activities.

F. Lessons Learned and Reflected in the Project Design

42. The project builds on the World Bank's health sector engagement in Kosovo, including the recently closed Kosovo Health Project (P147402) and the ongoing Kosovo Emergency COVID-19 Response Project (P173819). Activities are also informed by a series of studies produced by the Bank, including the Public Expenditure Review (2022), the Health System Review (2023), the State of NCDs in Kosovo (2023), and various policy notes on health financing reform and improving financial protection. Key lessons learned from past engagement include: (i) avoiding unnecessary complexity in project design, particularly in countries affected by fragility, conflict, and violence; and (ii) ensuring alignment with client priorities and building on established interventions, as appropriate and feasible. In addition, while coordination with other development partners is important for aid effectiveness, it is important to ensure that activities required to achieve the PDO are predominantly financed by the project.

43. In this context, project design focuses on select interventions for which there is political consensus and technical preparedness. Existing implementation arrangements that have shown success will be used, and project implementation will, to the extent possible, use country systems to minimize fragmentation and administrative burden. Project financing is incorporated into the public budget, and funds for the payments will flow through the Kosovo FM system. All project interventions are based on previous World Bank engagements as well as assessments (such as the eHealth feasibility study, GIZ assessment on HCWM, the WHO/European Center for Disease Control report on communicable diseases, etc.) that have informed the client's prioritization of needs. Finally, while all project interventions are closely coordinated with other donors and partners, their implementation is independent of any sequencing of other donor activities.

44. Furthermore, parallel resources for technical assistance are being secured to support the client in implementing Project activities. At the time of appraisal, a Bank-executed Trust Fund grant from the World Bank-Japan Policy and Human Resources Development Fund was awarded to support health financing and IHIS-related activities. An application will be submitted to the second round of calls for proposals from the Pandemic Fund to seek additional grant financing for the project by May 17, 2024.



G. Corporate Priorities

Citizen Engagement

45. A consultative approach to health sector development, which engages patients in the design and development of services, remains an important enabler of successful reforms. The project will use a proactive citizen engagement approach, based on regular and two-way communication and feedback cycles with project beneficiaries, civil society organizations, and health providers, through a series of Regional and National Health Forums. Specifically, the Regional Forums provide a platform to discuss concerns and feedbacks on QoC among key stakeholders at the local level. To ensure robust representation, Regional Forums will be publicized in advance through local media in local languages to encourage registration for in-person participation. Participants will be prioritized to ensure balanced representation.⁴⁸ Regions will then propose delegates to attend the National Health Forum. Proposed regional delegates will be considered for participation to ensure robust representation and may be revised, if needed. National Health Resolutions will be adopted as an outcome of National Health Forums to address local feedback. Such multi-level platforms can help consolidate the voice of citizens and stakeholders from the bottom to the national level and give them more leverage in influencing policies and monitoring policy implementation. Participation will be at no cost to citizens, without retribution, and will include suggestions, ideas, concerns, and grievances filed anonymously, in a manner consistent with the Environmental and Social Standard (ESS) 10.

Gender

46. Expansion of provider competencies for caring for those experiencing GBV is critical and has the potential to dramatically improve QoC for women. GBV is associated with a host of negative health and psychological outcomes and, as such, mitigation measures represent a life-saving component of proposed interventions.⁴⁹ As in other countries, Kosovo saw an increase in GBV during the pandemic and a decrease in social services due to lockdowns. In this context, healthcare providers at PHC facilities were often the first point of contact and a critical point for identification, treatment, and referral, for GBV-related services. Despite positive progress under the Kosovo Emergency COVID-19 Response Project (P173819) in training 86 doctors and 67 nurses to recognize and refer GBV victims, the curriculum of medical studies does not include GBV trainings⁵⁰ and most healthcare providers do not have any specific protocol on how to address and refer GBV cases. All this results in bottlenecks in services for victims and survivors. Consequently, scaling-up training of healthcare workers will strengthen the healthcare system's GBV response and support referrals. In this context, the project will scale-up ongoing training of PHC providers (Subcomponent 1.2) to increase provider sensitivity to and knowledge of GBV, improving their ability to provide care and/or refer cases for proper care, particularly in rural areas with ethnic minority and gender minority populations. Progress on this will be tracked by measuring the number of health workers trained, with the knowledge to recognize, medically manage, and refer GBV cases to appropriate services.

Climate

47. The project was screened for short- and long-term climate change and disaster risk. Average temperatures range from -27°C in winter to 39°C in summer and models predict that the region will get drier and warmer faster than the world average. Annual average rainfall is highest in the west (1,700 millimeters per year) and lowest in the east (600 millimeters per year). Precipitation has been declining since the 1980s and there has been increased intensity and frequency of precipitation extremes, including longer dry spells contributing to increased forest fires, and shorter and more intense precipitation periods leading to flash floods. Since 2000, Kosovo has lost 2.24 kilohectares of tree cover from fires.

⁴⁸ Balanced representation will take into account local demographic make-up and consider gender identity, race, ethnicity, age, ability, culture, education/literacy, income/socioeconomic status, language, religious beliefs, sexual orientation, geography/location, and technology knowledge/skill/comfort level, among others, as appropriate.

⁴⁹ Care International (May 2020). Gender Based Violence and COVID-19: The complexities of responding to "the shadow pandemic." https://www.care-international.org/files/files/GBV_and_COVID_19_Policy_Brief_FINAL.pdf

⁵⁰ UNICEF (October 2013). Study on Dimensions of Domestic Violence. Gender-based Violence in Kosovo Municipalities. https://www.unicef.org/kosovoprogramme/media/156/file/Final_Gender_based_violence_ENG.pdf



Similarly, flood damages are already significant and, on the rise, with approximately 10,000 population affected on average annually by flooding and affecting approximately US\$50 million of Kosovo's GDP on average annually. In addition, Kosovo has among the lowest levels of water resource development and storage in the region,⁵¹ and risk of earthquakes is high.

48. The project will address these vulnerabilities and enhance climate resilience and adaptation, while mitigating greenhouse gas emissions. Key actions and activities related to climate change adaptation and mitigation efforts planned in the project include: (i) direct investments in green technologies as part of infrastructure strengthening; (ii) sensitizing health staff to climate preparedness and prevention measures to minimize increases in illnesses following extreme weather events; (iii) behavior change communication on climate change and hazard; (iv) implementation of climate sensitive aspects in the national clinical practice guidelines to improve healthcare workers' ability to identify increases in AMR risk due to climate (through extreme heat and floods); and (v) measures to reduce risks from AMR for which climate is an important driver. Specifically regarding (i), the hardware purchase as part of Component 2 will be managed by including provisions of energy-efficiency requirements for such appliances and implementing the EU Directive on waste from electrical and electronic equipment, and the comprehensive investment in HCWM will focus on meeting energy-efficiency and environmental protection standards. Furthermore, by focusing on digitalization of medical records, guidelines, and tools, the project will in the long run lead to the decrease in the use of paper.

III. IMPLEMENTATION ARRANGEMENTS

A. Institutional and Implementation Arrangements

49. The MoH will be the overall Implementing Agency and will be responsible for the overall project implementation, including collaboration and coordination with relevant stakeholders (NIPH, HIF, health facilities, PHCs, etc.).

50. A Senior Management Committee (SMC), chaired by the Minister of Health and/or General Secretary, will be responsible for key decision making under the project. The SMC will include the relevant representatives of the MoH, HIF, NIPH, Digital Health Steering Committee/eHealth Body (see below), and other stakeholders. The detailed structure of the SMC will be defined in the Project's Operations Manual (POM). The SMC will be responsible for decision making related to the project, including approval of annual action and budget plans, and will address implementation bottlenecks. The SMC will be formed no later than 30 days after project effectiveness.

51. The PCU will facilitate day-to-day implementation of the project and act as a Secretariat to the SMC. The PCU, to be established not later than thirty days from effectiveness, will be coordinated by the Project Coordinator and will report to the General Secretary. In addition to the Project Coordinator, the PCU will consist, at a minimum, of a Procurement Specialist, an FM Specialist, a Monitoring and Evaluation Specialist, an IT Coordinator, a part-time Environmental and Social Specialist throughout project implementation, and a HCWM specialist for the period of implementation of HCWM activities, who will all report to the General Secretary. The PCU will be responsible for preparing annual work and budget plans for SMC approval. It will also be responsible for preparing semi-annual and annual progress reports and sharing them with relevant stakeholders.

52. Implementation of Component 2 will be based on the eHealth Feasibility Study and Strategic Plan for IHIS that envisages comprehensive digitalization of the overall health sector. Health sector digitalization is a long-term endeavor

⁵¹ Kosovo has an estimated 1,600 m³ of renewable water resources per person per year (16% of the regional average), while storage volume per capita is only 300 m³ (41% of the regional average).



that requires strong and sustainable institutional capacity to steer and manage the process.⁵² As such, a Digital Health Steering Committee (DHSC) led by the Minister of Health and comprising of representatives of key health sector institutions and key cross-sectoral stakeholders will be established no later than 60 days after project effectiveness to provide oversight and support policy decisions in the health aspect. The DHSC will be guided by and align with the National Digital Agenda 2030 and e-Governance Strategy which are coordinated with the Office of the Prime Minister's digital transformation unit. The digital health governance will build on existing digitalization governance structures to streamline the mandate and composition of the DHSC. Implementation responsibility (with a clear delineation of tasks) will be distributed between the Health Information Systems Department of the MoH, the University Clinical Center of Kosovo (UCCCK), and NIPH digital health implementation unit.

53. Details on the project's institutional and implementation arrangements will be set out in a POM, to be approved by the MoH within 30 days after project effectiveness. The POM will clearly describe the roles, responsibilities, and processes during project implementation.

B. Results Monitoring and Evaluation Arrangements

54. The PDO-level and intermediate outcome indicators will be monitored using routine reporting systems, including administrative and service delivery records and IHIS, once available. Project indicators have been selected based on strong alignment to project activities and the PDO, and where possible, include indicators which are already being monitored as part of existing strategic/action plans (e.g., Strategic Plan for Healthcare Waste Management).

55. Project monitoring and evaluation will be integrated into the regular monitoring functions of the MoH and respective institutions. The project will strengthen systems for performance management and monitoring of clinical outcome indicators by policy makers and facility managers. Project-supported activities related to digital health (i.e., IHIS) will contribute to improving the quality and reliability of the information obtained regularly by the MoH, HIF, and NIPH.

56. The overall responsibility for monitoring and evaluation will rest with the MoH, while the HIF and the NIPH will contribute to monitoring activities that are in their scope of work. The PCU will have a full-time monitoring and evaluation specialist who will be responsible for preparing progress reports, to be submitted to the World Bank not later than one month after the end of each calendar semester, covering the calendar semester, monitoring key performance indicators and results in collaboration with the MoH, HIF and NIPH, and providing information on implementation progress and results to the World Bank prior to each semi-annual implementation mission. The PCU will also be responsible for coordinating facility reports on infrastructure, equipment, and staffing, which can be substantiated with photographic evidence, as well as details on on-site visits. The PCU will also liaise with the MoH HIS department to ensure that the implementation of the IHIS (Component 2) is appropriately monitored and that change control⁵³ arrangements are respected.

⁵² One of the lessons learned from the implementation of the Project KSV/014 "Health Support Programme in Kosovo" that aimed at implementation of a comprehensive HIS was that separation of policy, implementation and operational governance layers is necessary to assure accountability and proper monitoring of the progress.

⁵³ Change control refers to formal processes to manage changes during the development and implementation of an IT project, including, but not limited to changes to target delivery date and/or project milestones, cost changes, for people or other resources required to deliver the project, technical changes (e.g., a shift to a new technology or software, changes in assumptions and/or priorities, staffing, etc.



C. Sustainability

57. The sustainability of the activities supported by the project can be assessed through two perspectives: political and institutional stability. In terms of political sustainability, the Government is committed to reforming its health sector and improving QoC. These objectives are set out in the Government Program (2021-2025) and the Health Sector Strategy for 2024-2030. The project contributes to these objectives by supporting the Government to strengthen institutional and governance capacities around QoC and to develop a crosscutting integrated HIS to serve as the foundation for broader reforms. From this perspective, the activities are well aligned with the country's priorities, which suggests political sustainability. In terms of institutional sustainability, the project focuses on areas that will strengthen institutional capacity on QoC. First, the project will support strengthening governance processes around the development of clinical guidelines, capacity building on adoption of clinical care pathways, and establishment of institutional mechanisms for monitoring quality indicators, which will be integrated into the daily routine work of health facilities. A substantial proportion of project activities focus on training and TA to support healthcare institutions in delivering the QoC reforms, which is intended to ensure that activities supported by the project are sustainable and scalable even beyond the project implementation period.

IV. PROJECT APPRAISAL SUMMARY

A. Technical and Economic Analysis

Technical Appraisal

58. The PDO will be achieved through a sound design, which balances investments in infrastructure with other interventions designed to improve health system effectiveness. Project design is informed by the World Bank's track record of implementing similar interventions in other countries. The technical approach for each component is based on international experience of high-performing EU and upper-middle-income countries, taking into account both the past experience with the implementation of health reforms in Kosovo and the current and planned strategies for health sector reforms in the next five years. This includes the Action Plan of the National Program on Communicable Diseases (2022), the Action Plan for HCWM (2023), and the Kosovo eHealth Feasibility Study, all of which have already been adopted, as well as the Kosovo Health Sector Strategy for 2024-2030, which is expected to be finalized by mid-2024.

59. The Project is aligned with the goals of the Paris Agreement on both mitigation and adaptation.

- **Assessment and reduction of mitigation risks:** Mitigation risks are low. The majority of activities supported by the project are universally aligned, with the exception of the limited civil works which were assessed as low risk due to their limited scope and impact on Kosovo's decarbonization pathways. Nevertheless, measures are taken to reduce the operational energy needs of the buildings by e.g., using thermal insulation and purchasing of energy-efficient equipment.
- **Assessment and reduction of adaptation risks:** Climate hazards that can pose a hazard to the project activities include extreme precipitation and flooding, and extreme temperatures. Location of civil works is not yet determined; however, all sites selected will undergo an assessment of potential climate risks and will identify measures to ensure their climate resilience and to reduce residual risks to acceptable levels. Measures may include the use of thermal insulation to protect against extreme temperature, engineering design to increase flood resilience, and introduction of back-up power generation and/or provision of water supply as necessary in case of an interruption due to a climatic event. Locations where risks cannot be reduced to acceptable levels will be excluded.

Economic Analysis

60. Investments in PPR and health system quality improvement have been shown to be highly cost-effective, as they improve population health in an equitable manner which yields large economic returns. Investments in improved



efficiency, equity, and quality of the types of services which will be affected by this project are welfare enhancing, as they are associated with reductions in morbidity and mortality, which, in turn, yield substantial economic gains.^{54,55}

61. A cost-benefit analysis was carried out to assess the economic viability of the project; it is deemed to be cost-beneficial. The costs and benefits of the project have been estimated for the 2023–40 period. The main direct benefit derives from the economic value of averted disability-adjusted life years (DALYs) and the cost savings generated by reduced risk factors for AMR. The most conservative scenario, which considers the least cost of DALYs averted (i.e., one DALY = GDP per capita) and a higher discount rate (five percent) results in a Net Present Value of US\$ 48.068 million, a 74 percent Internal Rate of Return, and a Benefit Cost Ratio of 3.78. Increasing the value of a DALY from one to three times the GDP per capita and applying a discount rate of three percent raises the Net Present Value to US\$ 211.826 million and the Benefit Cost Ratio to 12.56. In contrast, the Internal Rate of Return was not very sensitive to the discount rate for DALYs averted. Note that the analysis only assesses the AMR aspect of the project and, hence, the estimated results do not reflect the full benefits of the project as a whole. The results should be considered a lower-bound estimate of the project benefits. Alternative scenarios and their effect on the project’s economic performance are presented in Annex 4.

62. With the Government of Kosovo facing substantive gaps in financial and technical capacity, World Bank support is essential for the implementation of crucial PPR, health system, and health financing reforms. With experience and engagement in the Kosovo health sector and close ties to other development partners in the country (especially WHO), the World Bank is uniquely placed to technically support the Government’s reform efforts. Moreover, given the fiscal constraints that have been further exacerbated by the COVID-19 pandemic and limited external financing for health, the project will play a critical role in the implementation of the Government’s Action Plan of the National Program on Communicable Diseases (2022) and Health Sector Strategy for 2024-2030.

B. Fiduciary

Financial Management

63. The overall FM arrangements meet the minimum requirements of the World Bank’s Policy and Directive on Investment Project Financing (IPF). Financial management responsibility for the project will remain with the MoH, through its Budget and Finance department. The project will rely extensively on the various elements of Kosovo’s public financial management (PFM) systems, including organizational hierarchy, budget classification and program structure, reporting and expenditure monitoring systems, Treasury function, internal control framework, and external audit. The World Bank team assessed such systems, MoH structure, and FM practice in MoH. The main findings are as follows: (i) existing FM staff are overloaded and need hands-on support to comply with World Bank requirements; (ii) recent audits identified a few noncompliance cases in the area of commitment control and fixed assets recording; (iii) recurring issues with budgetary allocations in the previous projects (timeliness, adequacy); and (iv) PFM reviews identify the areas for attention which include better quality and coordination for budget planning for investments, strengthening control framework, improving quality of internal audits, and enhancing capital investment management. In response to the identified risks, the following measures have been agreed to strengthen the FM systems for the project: (i) the POM will describe the FM, disbursement, and enhanced internal control policies and procedures; (ii) a qualified FM Specialist will be hired under the PCU to support the MoH; (iii) capacity building and training will be provided to all FM staff. To manage risks associated with the budget, the MoH is required to implement an effective and documented project planning and contract monitoring process, while the World Bank team will review the annual work plan and monitor the annual budget

⁵⁴ Tandon et al. 2021. Making the Case for Health: A Messaging Guide for Domestic Resource Mobilization. Joint Learning Network for Universal Health Coverage.

⁵⁵ WHO and World Bank, *Analysis of PPR architecture, financing needs, gaps and mechanisms*, Prepared for the G20 Joint Finance & Health Task Force (G20-Gaps-in-PPR-Financing-Mechanisms-WHO-and-WB-pdf.pdf (worldbank.org)).



formulation process. As a prerequisite, the MoH needs to reflect project spending forecast into annual budget documentation. The financial management risk after mitigation measures is moderate.

64. Disbursements under the project will be managed by the MoH and carried out in line with the World Bank Disbursement Guidelines for IPF (February 2017). Project activities will be wholly financed by the IDA credit. Project funds will be disbursed through traditional IPF disbursement methods. The advance method and Designated Account (DA) will be used only if requested by the recipient. If so, a segregated DA, denominated in Euros will be opened at the Central Bank of Kosovo, as a subaccount linked to the Single Treasury Account. Funds advanced to the DA will be based on a six-month spending forecast and will be earmarked for the project. The FM reporting requirements consist of: (a) quarterly interim unaudited financial reports (IFRs), in the form and substance agreed with the World Bank, will be submitted to the World Bank no later than 45 days after the end of each quarter; and (b) annual Project Financial Statements will be audited by independent auditors under terms of reference acceptable to the World Bank. The audited financial statements will be presented to the World Bank no later than six months after the end of the fiscal year and made publicly available in a manner acceptable to the World Bank.

Procurement

65. Procurement will be carried out in accordance with the following World Bank procedures: World Bank Procurement Regulations for IPF Borrowers, fourth edition, dated September 2023; Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants, dated October 15, 2006, and revised in January 2011 and Anti-Corruption Guidelines as of July 1, 2016; and other provisions stipulated in the Financing Agreements. The World Bank's Standard Procurement Documents will govern the procurement of World Bank-financed Open International Competitive Procurement. Mandatory Procurement Prior Review Thresholds detailed in Annex I of the Bank's Procurement Procedure will be observed. For bidding processes with a national market approach, bidding and requesting quotations documents will use standard procurement documents acceptable to the World Bank. These will be included in the POM.

66. The MoH, with the support of the existing PCU implementing the Kosovo Emergency COVID-19 Response Project (P173819), has developed the Project Procurement Strategy for Development, which describes how procurement in this operation will support the attainment of the PDOs and deliver value for money under a risk-based approach. It also provides adequate supporting market analysis for the selection methods detailed in the Procurement Plan.

67. From a procurement perspective, the fiduciary risk rating is Moderate. The key issues and risks concerning procurement for project implementation include: (i) the complexities of procuring IT systems and hardware; (ii) supervision and management of the implementation of various IT systems; and (iii) coordination between relevant stakeholders and potential risks in complex inter-institutional arrangements. The corrective measures that were agreed upon are to: (i) support the PCU to keep the previously trained procurement specialist in the project implementation team; (ii) define in the POM appropriate roles and responsibilities of the technical and procurement units; (iii) clearly define in the POM the roles, responsibilities, and functions, including the interaction between the different stakeholders; (iv) provide the PCU with solid capacity to design, evaluate and manage the implementation and integration of IT systems; and (v) continued training and workshops on World Bank Procurement regulations for procurement specialists and PCU Team.

68. As per paragraph 5.9 of the Procurement Regulations, the World Bank's Systematic Tracking and Exchanges in Procurement system will be used to prepare, clear, and update Procurement Plans and conduct all procurement transactions for the project. The Recipient will prepare the Procurement Plan based on the results provided by the Project Procurement Strategy for Development, including a timeline for implementing procurement processes covering at least the first 18 months of project implementation, and agreed upon.



69. The major planned procurements include:

- Goods: (i) replacement of outdated equipment (Autoclaves) for treatment of medical waste; (ii) assessment/design and investment in the Master Data Management system; and (iii) procurement of hardware for IHIS building blocks.
- Civil works: Construction/adaptation of safe storage spaces (warehouses) for infectious and sharp waste.
- Consulting Services: (i) hiring of a consulting company to guide initial implementation; (ii) design and implementation of the HMIS; (iii) design and implementation of the central LIS; and (iv) design and implementation of the Radiology Information System, including Picture Archiving and Communication Systems.

C. Legal Operational Policies

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

D. Environmental and Social

70. The environmental and social risks of the project are Moderate, mainly because of the civil works. These include rehabilitation and refurbishment of a room in each health facility to be used for daily storage of healthcare waste and for reconstruction/adaptation of treatment facilities in UCCK and seven regional hospitals, rehabilitation of existing central warehouse to add space for pharmaceutical waste and the activities of healthcare waste. If identified in a timely manner, and if all mitigation measures are adequately applied, the environmental and social impacts that may occur from these civil works are expected to be both moderate in magnitude and temporary. The impact of these activities should be typical for construction works, e.g., noise emission, dust emission, wastewater, construction waste, and risks to workers, certain occupational and health risks, working at height, welding, hot work, and working with chemicals, which will be addressed by introducing adequate occupational health and safety measures. An Environmental and Social Management Framework (ESMF) has been prepared, publicly consulted, and disclosed in country (on the Ministry of Health site at <https://msh.rks-gov.net/>), on February 2, 2024 and identifies the expected adverse environmental and social impacts and risks and proposes the approach to manage them. Besides other provisions, the ESMF includes an analysis of existing gaps between World Bank ESS and national environmental and social standards and defines the responsibilities for Environmental and Social Framework (ESF) implementation and mitigation measures, a methodology for environmental and social risks and adverse impacts screening, as well as a list of non-eligible activities. The ESMF includes provisions for the avoidance of any sensitive environments or protected areas, guidance on cultural heritage or chance finds as stipulated under ESS 8, and includes provisions of energy efficiency, as per the World Bank Environmental, Health, and Safety General Guideline and relevant good international industry practices. In addition, the ESMF includes provisions on adequate HCWM in line with national legal procedures and the World Bank’s Environment Health and Safety General guidelines and requirements. The project will be implemented in accordance with the World Bank ESSs; therefore, an Environmental and Social Commitment Plan was prepared, consulted, and disclosed in-country (with other instruments at <https://msh.rks-gov.net/>). The Environmental and Social Commitment Plan sets out material measures and actions that the Recipient shall carry out or cause to be carried out, including, as applicable, the timeframes of the actions and measures, institutional, staffing, training, monitoring, and reporting arrangements, and grievance management, for the project to comply with the ESSs and national environmental and social standards. The capacity to carry out environmental and social activities within the



project will be strengthened through the hiring of an experienced Environmental and Social/Citizen Engagement specialist and a healthcare waste management specialist.

71. No land acquisition or involuntary resettlement impacts are expected to occur under the project, since all the works are planned to be within the existing premises of the relevant hospitals.

72. The TA activities supported by the project will be managed such that advisory and other support provided is aligned with the relevant ESSs. The Stakeholder Engagement Plan and Labor Management Procedures were prepared, publicly consulted, and disclosed in-country to guide stakeholder management and labor and working conditions, in accordance with ESS 10 and ESS 2.⁵⁶

73. The project Grievance Redress Mechanism (GRM) has been functioning very well under the Kosovo Emergency COVID-19 Project (P173819); along with this, the team has developed capacities in managing the GRM. The GRM for this project will be set up upon PCU establishment and equipped to receive sensitive and anonymous complaints.

V. GRIEVANCE REDRESS SERVICES

74. Grievance Redress. Communities and individuals who believe that they are adversely affected by a project supported by the World Bank may submit complaints to existing project-level grievance mechanisms or the Bank’s Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address project-related concerns. Project affected communities and individuals may submit their complaint to the Bank’s independent Accountability Mechanism (AM). The AM houses the Inspection Panel, which determines whether harm occurred, or could occur, as a result of Bank non-compliance with its policies and procedures, and the Dispute Resolution Service, which provides communities and borrowers with the opportunity to address complaints through dispute resolution. Complaints may be submitted to the AM at any time after concerns have been brought directly to the attention of Bank Management and after Management has been given an opportunity to respond. For information on how to submit complaints to the Bank’s Grievance Redress Service (GRS), visit <http://www.worldbank.org/GRS>. For information on how to submit complaints to the Bank’s Accountability Mechanism, visit <https://accountability.worldbank.org>.

VI. KEY RISKS

75. The project’s overall residual risk, after mitigation, is Moderate. Political and governance, macroeconomic, technical design, fiduciary, environmental and social, and stakeholder residual risks are moderate. Other risks are outlined below.

Category of risk	Risk description	Mitigation in place or planned	Risk after Mitigation
1. Sector Strategies and Policies	Failure to follow through on stated sector strategies or policies due to opposition by vested interests or lack of funding	Planning for the implementation of the health financing strategy and QA/QM initiatives will require high-level MoH management support and extensive consultation with affected groups to build a high level of public and professional support. Other policy aspects of the project are not expected to be controversial. Intensive policy dialogues and engagement by the World Bank team have helped build consensus on health reforms (through the Round Table on the Public Expenditure	Substantial

⁵⁶ Disclosed on February 2, 2024 at <https://msh.rks-gov.net/>



Category of risk	Risk description	Mitigation in place or planned	Risk after Mitigation
		Review (March 2023), study visit to Germany (June 2023), Flagship Course on Health System Strengthening (August 2023), an NCD event (planned September 2023).	
2. Institutional Capacity for Implementation/ Sustainability	<p>Planned reforms fail due to lack of implementation and/or operational capacity</p> <p>Planned reforms fail due to poor public perceptions or resistance from health care workers and/or providers</p>	<p>The project will include extensive capacity-building initiatives to increase institutional capacity and draw on related expertise from other countries which have implemented similar reforms. Project financing is expected to be complemented by Trust Fund resources to provide additional TA.</p> <p>Robust client engagement mechanisms will be put in place for the public, and engagement mechanisms will also be put in place for health workers and providers to explain the content and rationale for the proposed reforms and solicit feedback to address ongoing concerns or resistance.</p>	Substantial



VII. RESULTS FRAMEWORK AND MONITORING

PDO Indicators by PDO Outcomes

Baseline	Period 1	Period 2	Period 3	Closing Period
1. Strengthen key health system building blocks for quality of care				
Ratings on a five-point scale for indicators in the CAESAR Network Assessment (Number)				
Jan/2024	Mar/2026	Mar/2027	Mar/2028	Mar/2029
1	1	2	2	3
➤ Ratings on a five-point scale for indicator #8 (IPC in human health care) (Number)				
Jan/2024	Mar/2026	Mar/2027	Mar/2028	Mar/2029
1	1	2	2	3
➤ Ratings on a five-point scale for indicator #9 (Optimizing antimicrobial use in human health) (Number)				
Jan/2024	Mar/2026	Mar/2027	Mar/2028	Mar/2029
1	1	2	2	3
PHC facilities and hospitals reporting on a set of nationally adopted QoC indicators in the public domain (Percentage)				
Jan/2024	Mar/2026	Mar/2027	Mar/2028	Mar/2029
0	10	30	50	80
➤ Hospitals reporting on a set of nationally adopted QoC indicators in the public domain (Percentage)				
0	13	38	63	88
➤ PHCs reporting on a set of nationally adopted QoC indicators in the public domain (Percentage)				
Jan/2024	Mar/2026	Mar/2027	Mar/2028	Mar/2029
0	10	30	50	80
2. Develop an integrated health information system				
Hospital outpatient specialist visits with electronic referrals (Percentage)				
Jan/2024	Mar/2026	Mar/2027	Mar/2028	Mar/2029
0	10	40	70	90

Intermediate Indicators by Components

Baseline	Period 1	Period 2	Period 3	Period 4	Closing Period
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1. Strengthening key health system building blocks for quality of care					
KHUCS clinics and General Hospitals participating in the AMR stewardship program (Number)					
Mar/2024	Mar/2026	Mar/2027	Mar/2028		Mar/2029
0	7	10	14		14
Health workers trained in good AMR, HAI and HCWM practices (Number)					
Mar/2024	Mar/2026	Mar/2027	Mar/2028		Mar/2029
0	600	1,500	2,500		3,600
Annual National and Regional Health Forums (including formalized citizen engagement and empowerment) (Number)					
Mar/2024	Mar/2025	Mar/2026	Mar/2027	Mar/2028	Mar/2029
0	1	2	5	6	8
➤ Annual National Health Forums (Number)					
Mar/2024	Mar/2025	Mar/2026	Mar/2027	Mar/2028	Mar/2029
0	0	1	0	2	2
➤ Annual Regional Health Forums (Number)					
Mar/2024	Mar/2025	Mar/2027	Mar/2028		Mar/2029
0	1	3	4		6
Adoption of National Health Resolutions developed through consultative citizen feedback (Number)					
Jan/2024	Mar/2026	Mar/2028			Mar/2029
0	1	2			2
Clinical practice guidelines/protocols/pathways developed and approved (Number)					
Dec/2023	Mar/2025	Mar/2026	Mar/2027	Mar/2028	Mar/2029
4	25	45	65	85	110
Health care workers attended at least one in-service training in QoC in the past year (Number)					
Mar/2024	Mar/2026	Mar/2027	Mar/2028		Mar/2029
0	300	700	1,500		2,500
PHC clinical audits and feedback conducted by PHC coordinators in the past year using the new PHC clinical audit and feedback manual (Number)					
Mar/2024	Mar/2026	Mar/2027	Mar/2028		Mar/2029
0	4	10	20		30
Health inspectors trained in the new inspection standards (Number)					
Mar/2024	Mar/2026	Mar/2027	Mar/2028		Mar/2029
0	10	30	60		100
Number of drugs included in the ODBP (Number)					
Mar/2024	Mar/2025	Mar/2026	Mar/2027	Mar/2028	Mar/2029
0	10	20	40	70	100



Health workers and associated professionals trained with the knowledge to recognize, medically manage (as applicable), and refer GBV cases to appropriate services (Number)					
Jan/2024	Mar/2026	Mar/2027	Mar/2028		Mar/2029
153	220	360	480		550
People benefitting from strengthened capacity to prevent, detect, and respond to health emergencies (Number)					
Jan/2024					Mar/2029
0					TBD
2. Developing an integrated health information system					
A digital health governance structure has been established (Yes/No)					
Mar/2024	Mar/2025				Mar/2029
No	Yes				Yes
Foundational registries established (Number)					
Mar/2024	Mar/2025	Mar/2026	Mar/2027		Mar/2029
0	3	6	7		8
Primary care visits registered in the BHIS (Percentage)					
Mar/2024					Mar/2029
11.6					95
PHC facilities that have fully functional BHIS (Percentage)					
Mar/2024	Mar/2025	Mar/2026	Mar/2027	Mar/2028	Mar/2029
32.8	35	50	75	90	95
Electronic care pathways integrated in BHIS (Number)					
Mar/2024	Mar/2026	Mar/2027	Mar/2028		Mar/2029
0	5	10	20		30
Health workers trained in enhanced BHIS and HMIS (Number)					
Mar/2024	Mar/2026	Mar/2027	Mar/2028		Mar/2029
0	3,000	6,000	9,000		12,000
Regional Hospitals and UCCK clinics that have HMIS installed and in operation (Number)					
Mar/2024	Mar/2028				Mar/2029
0	9				37
➤ Number of Regional Hospitals that have HMIS installed and in operation (Number)					
Mar/2024	Mar/2028				Mar/2029
0	3				7
➤ Number of UCCK clinics that have HMIS installed and in operation (Number)					
Mar/2024	Mar/2028				Mar/2029
0	6				30



People using digitally-enabled health services (Number)					
Jan/2024					Mar/2029
0					TBD
3. Project Management, Monitoring, and Evaluation					



Monitoring & Evaluation Plan: PDO Indicators by PDO Outcomes

Component 1. Strengthen key health system building blocks for quality of care	
1. Ratings on a five-point scale in the CAESAR Network Assessment (for indicators #8 (IPC in human health care) and #9 (optimizing antimicrobial use in human health))	
Description	This indicator uses the five-point rating scale for the CAESAR assessment and converts it to a numerical value (Poor (1), Fair (2), Good (3), Very good (4), Excellent (5)). In the CAESAR report, these indicators reflect Status of development and implementation of the main IPC and AMR measures at the national level.
Frequency	Annual (contingent on reporting by NIPH)
Data source	NIPH AMR program
Methodology for Data Collection	Annual questionnaire submitted to CAESAR
Responsibility for Data Collection	NIPH AMR program/PCU
2. PHC facilities and hospitals reporting on a set of nationally adopted QoC indicators in the public domain	
Description	Numerator: Total number of facilities (PHC facilities/hospitals) which produced a quality indicator report at least quarterly and shared it in the public domain. Denominator: Total number of facilities (PHC/hospitals) from Kosovo Agency of Statistics (KAS).
Frequency	Quarterly
Data source	MoH website, PCU monitoring and evaluation system, KAS
Methodology for Data Collection	(a) Review reports published on the MOH website and produce a tally of those facilities which have produced a quality indicator report at least 4 times in a fiscal year; (b) obtain data on the number of facilities from KAS; (c) divide (a) by (b) and multiply by 100.
Responsibility for Data Collection	PCU to collate, MoH and KAS to supply information
Component 2. Develop an integrated health information system	
3. Hospital outpatient specialist visits with electronic referrals	
Description	Numerator: Total number of hospital outpatient specialist (non-emergency) visits which were facilitated with an electronic referral. Denominator: Total number of hospital outpatient specialist (non-emergency) visits.
Frequency	Annual
Data source	Numerator: HMIS (MoH IT department); Denominator: Annual reports on hospital specialist visits (KAS)
Methodology for Data Collection	(a) Generate report on electronic referrals from HMIS; (b) obtain annual filing on outpatient visits from KAS; (c) divide (a) by (b), multiply by 100
Responsibility for Data Collection	PCU to collate, MoH IT department and KAS to supply information

Monitoring & Evaluation Plan: Intermediate Results Indicators by Components

Component 1. Strengthen key health system building blocks for quality of care	
1.1. KHUCS clinics and general hospitals participating in the AMR stewardship program	
Description	Number of UCCK hospital departments/regional hospitals participating in the AMR stewardship program. The Standard Operating Procedures of this program have been approved. The program will first be implemented in six departments of UCCK (adult intensive care unit, neonatal intensive care unit, pediatrics, infectious disease, lung disease, surgery). It will be expanded to high-risk departments of regional hospitals.
Frequency	Annually
Data source	NIPH AMR Program, PCU monitoring and evaluation system
Methodology for Data Collection	Annual survey of relevant hospital departments to determine which ones are actively implementing the AMR stewardship program
Responsibility for Data Collection	PCU/NIPH AMR Program
1.2. Health workers trained in good AMR, HAI and HCWM practices	



Description	Improved knowledge by health workers of good AMR, HAI and HCWM practices is key to improving results in this area. This indicator would measure the cumulative number of health workers trained in any of the topics (AMR, HAI and HCWM) under the project.
Frequency	Ongoing
Data source	PCU monitoring and evaluation system
Methodology for Data Collection	Records of all training activities under the relevant sub-component
Responsibility for Data Collection	PCU
1.3. Annual National and Regional Health Forums (including formalized citizen engagement and empowerment)	
Description	Annual health forums, which include citizen engagement and empowerment, are a key activity to promote a QoC culture throughout the health system. This indicator would measure the cumulative number of national and regional health forums which included formalized citizen engagement and empowerment aspects as an integral part of the forum design.
Frequency	Annual
Data source	PCU monitoring and evaluation system
Methodology for Data Collection	Records of all forums financed under the relevant sub-component
Responsibility for Data Collection	PCU
1.4. Adoption of National Health Resolutions developed through consultative citizen feedback	
Description	National Health Resolutions will be adopted as an outcome of National Health Forums to address local feedback. Such multi-level platforms can help consolidate the voice of citizens and stakeholders from the bottom to the national level and give them more leverage in influencing policies and monitoring policy implementation.
Frequency	Annual
Data source	PCU monitoring and evaluation system
Methodology for Data Collection	Records of all forums financed under the relevant sub-component
Responsibility for Data Collection	PCU
1.5. Clinical practice guidelines/protocols/pathways developed and approved	
Description	Cumulative number of clinical practice guidelines, protocols and/or clinical pathways that have been developed and approved. As of December 2023, 25 guidelines and protocols have been developed with approval planned for 2024. An additional 21 guidelines and 10 protocols are planned to be developed in 2025.
Frequency	Annual
Data source	MoH/NIPH//PCU monitoring and evaluation system
Methodology for Data Collection	Obtain copies of guidelines, protocols and pathways once they are approved
Responsibility for Data Collection	MoH/PCU
1.6. Health care workers attended at least one in-service training in QoC in the past year	
Description	Cumulative number of health workers who have attended at least one in-service training in QoC financed by the project. Excludes training in AMR, HAI and HCWM practices, which are expected to be captured separately by indicator 1.2
Frequency	Ongoing
Data source	PCU monitoring and evaluation system
Methodology for Data Collection	Records of all training activities under the relevant sub-component
Responsibility for Data Collection	PCU
1.7. PHC clinical audits and feedback conducted by PHC coordinators in the past year using the new PHC clinical audit and feedback manual	
Description	Number of clinical audits (including feedback) that have been performed each year in PHC facilities using the manual.
Frequency	Annual
Data source	MoH/PCU monitoring and evaluation system
Methodology for Data Collection	Record the number of clinical audits which included feedback by all PHC coordinators during the year



Responsibility for Data Collection	PCU/MoH
1.8. Health inspectors trained in the new inspection standards	
Description	Cumulative number of health inspectors who have been trained in the new standards under the project.
Frequency	Ongoing
Data source	PCU monitoring and evaluation system
Methodology for Data Collection	Records of all training activities under the relevant sub-component
Responsibility for Data Collection	PCU
1.9. Number of drugs included in the ODBP	
Description	As part of the limited set of health financing activities (awaiting adoption of new legislation), support will be provided for the implementation of the ODBP. This indicator measures the number of outpatient drugs which are included as part of the benefit plan
Frequency	Updated annually once the ODBP has started implementation
Data source	MoH/HIF/PCU monitoring and evaluation system
Methodology for Data Collection	Obtain copy of document authorizing the ODBP drug list once the ODBP has begun implementation
Responsibility for Data Collection	MoH/PCU
1.10. Health workers and associated professionals trained with the knowledge to recognize, medically manage (as applicable), and refer GBV cases to appropriate services	
Description	This indicator measures progress of trained healthcare workers and associated professionals, such as social workers, in selected facilities and who gain the knowledge to recognize and refer GBV victims and refer them for onward care. It builds off work under P173819, under which 86 doctors and 67 nurses (153 total staff) were trained as of January 2024.
Frequency	Annual
Data source	Training reports/MoH
Methodology for Data Collection	Records of all training activities under the relevant sub-component
Responsibility for Data Collection	PCU
1.11. People benefitting from strengthened capacity to prevent, detect, and respond to health emergencies (Number)	
Description	The number of people benefitting directly and indirectly from improvements in countries' capacity to prevent, detect, and respond to health emergencies. It will consider how interventions enhance the capacity of health systems to prevent, detect, and respond to outbreaks, and the projected individual benefit that is likely to come from Project investments. This is a new WBG Scorecard indicator.
Frequency	Annual
Data source	MoH
Methodology for Data Collection	TBD (being developed by the designated WBG working group for this indicator)
Responsibility for Data Collection	MoH/PCU
Component 2. Information systems to monitor and improve care	
2.1. A digital health governance structure has been established	
Description	Implementation of IHIS is complex program that requires clear institutional responsibilities at least on: (a) policy and regulatory framework; (b) executive implementation management; and (c) health data governance. This indicator measures whether a key prerequisite - the digital health governance structure - is in place.
Frequency	Updated once governance structure is established
Data source	MoH IT department
Methodology for Data Collection	Obtain copy of Administrative Instruction or other document establishing the structure and verify through direct observation that the structure is in place



Responsibility for Data Collection	MoH/PCU
2.2. Foundational registries established	
Description	Foundational registries are basic building blocks for HIS interoperability and integration. This indicator measures how many of these registries have been created in an appropriate electronic format. At minimum, the following foundational registries will be established as electronic, online systems: Master Patient Index, registry of health facilities, registry of health professionals, diagnostic and procedure coding systems, and drugs coding and classification.
Frequency	Annual (updated once each registry is established)
Data source	MoH IT department/PCU monitoring and evaluation system
Methodology for Data Collection	Verify through direct observation that each registry is in place and accessible on-line.
Responsibility for Data Collection	MoH/PCU
2.3. Primary care visits registered in the BHIS	
Description	Percent of total primary care visits that are registered in the BHIS (among the 29 municipalities that are currently using the system). Numerator: number of primary care visits registered in the BHIS. Denominator: number of primary care visits in the relevant municipalities.
Frequency	Annual
Data source	Numerator: BHIS (MoH IT department); Denominator: Annual reports on PHC visits (KAS)
Methodology for Data Collection	(a) Generate report on PHC visits registered in BHIS; (b) obtain annual filing on total PHC visits among the 29 municipalities from KAS; (c) divide (a) by (b), multiply by 100
Responsibility for Data Collection	PCU to collate, MoH IT department and KAS to supply information
2.4. PHC facilities that have fully functional BHIS	
Description	Percent of PHC facilities (among the 29 municipalities that are currently using the system) which have addressed these issues and have a fully functional BHIS. Numerator: number of PHC facilities which have deployed the upgraded BHIS and fully addressed connectivity and hardware issues. Denominator: total number of PHC facilities in the relevant municipalities.
Frequency	Annual
Data source	Numerator: BHIS (MoH IT department, based on agreed criteria which deem the BHIS in a particular PHC facility to be "fully functional"); Denominator: Annual report on the number of PHC facilities in the 29 municipalities (KAS)
Methodology for Data Collection	(a) MoH IT department, together with PCU, to score each health facility which is using BHIS to determine how many are "fully functional;" (b) obtain annual filing on total PHC facilities in the 29 municipalities from KAS; (c) divide (a) by (b), multiply by 100. Note: The definition of "fully functional" will be established once the full extent of the upgrades to BHIS have been determined.
Responsibility for Data Collection	PCU to collate, MOH IT department (together with PCU) and KAS to supply information
2.5. Electronic care pathways integrated in BHIS	
Description	Cumulative number of clinical pathways that have been coded into BHIS. Adherence to clinical care pathways to maintain standards of clinical care is most effective when integrated into the BHIS. This indicator monitors the integration of these pathways into the BHIS.
Frequency	Annual
Data source	BHIS; PCU monitoring and evaluation system
Methodology for Data Collection	MoH IT department to advise PCU of the number of clinical care pathways that have been coded in BHIS; PCU to verify via direct observation
Responsibility for Data Collection	MoH/PCU
2.6. Health workers trained in enhanced BHIS and HMIS	
Description	Cumulative number of health workers, administrative, managerial, and technical facility personnel trained in the new information systems (HMIS, BHIS and change management) under the project.
Frequency	Ongoing



Data source	PCU monitoring and evaluation system
Methodology for Data Collection	Records of all training activities under the relevant sub-component
Responsibility for Data Collection	PCU
2.7. Regional Hospitals and UCCK clinics that have HMIS installed and in operation	
Description	Installed and in operation: (a) clinical information can be entered at the bedside in over 50% of hospital beds currently in use; (b) over 50% of the specialist physicians working in the facility use the information system to enter clinical data on patient encounters; (c) over 50% of data capable laboratory analyzers are connected to the system and passing laboratory results into patient files.
Frequency	Annual
Data source	HMIS, direct observation, and PCU monitoring and evaluation system
Methodology for Data Collection	(a) establish the threshold values for each of the three criteria for each regional hospital; (b) once a hospital has implemented HMIS, conduct a site visit (MoH IT department and PCU) to determine if the criteria have been met; (c) if the criteria have not been met, schedule additional site visits until criteria are met.
Responsibility for Data Collection	MoH IT department/PCU
2.8. People using digitally-enabled health services	
Description	The number of people, public sector locations, and businesses who use new or enhanced digitally enabled services. This includes new digitally delivered services, previously-manual/analog services that are enhanced through digitalization, as well as enhancements to existing digitally delivered services. This is a new WBG Scorecard indicator
Frequency	Annual
Data source	IHIS
Methodology for Data Collection	TBD (being developed by the designated WBG working group for this indicator)
Responsibility for Data Collection	MoH IT department/PCU



ANNEX 1: Implementation Arrangements and Support Plan

1. The MoH will be responsible for the implementation of the project. The directors of relevant departments of the MoH, including the head of Strategic Planning and Policy Department, head of HIS Department, head of Primary Healthcare Division, head of Hospital Services Department, head of Inspectorate and Healthcare Waste Management, as well as the directors of the HIF, KHUCS and NIPH, will be responsible for the technical implementation of project sub-components and activities. The project will, therefore, require clear implementation oversight and regular consultation among key stakeholders, as well as decision making mechanisms to prevent and address bottlenecks. To facilitate this, an SMC will be established under the MoH.
2. Project oversight will be the responsibility of the SMC, chaired by the Minister of Health or General Secretary, and consisting of, but not limited to, heads/representatives from the Strategic Planning and Policy Department, HIS Department, PHC Division, Hospital Services Department, Health Inspectorate, Healthcare Waste Management, Donor Coordination Office in the Department for Policy Co-ordination and European Integration as well as the directors/representatives of the HIF, KHUCS and NIPH. The SMC will meet at least on a semi-annual basis and on an ad-hoc basis, as required, to provide policy guidance, review and approve annual work and budget plans, and make relevant decisions to resolve implementation bottlenecks. The project SMC shall be established within 30 days upon project effectiveness.
3. Implementation of the Component 2 is based on eHealth Feasibility Study and Strategic Plan for IHIS that envisages comprehensive digitalization of the overall health sector. A DHSC will be established no later than 60 days after effectiveness and will be in charge of digital health policy making, regulations, and health data governance. The DHSC will be guided by and align with the National Digital Agenda 2030 and e-Governance Strategy which are coordinated with the Office of the Prime Minister's digital transformation unit. The MoH will distribute institutional responsibility for executive level of implementation between the MoH HIS department, KHUCS, and NIPH's respective digital health implementation unit. The head of DHSC will sit on the project's SMC.
4. A PCU would be established within the MoH (under component 3) to support day-to-day project management and implementation. The PCU will be responsible for procurement, FM and reporting on the use of project funds. It would include core staff responsible for technical and fiduciary management and would consist of a full-time Project Coordinator, Procurement Specialist, FM Specialist, a Monitoring and Evaluation Specialist, an IT coordinator, a part-time ESF Specialist, and a HCWM specialist for the period of implementation of HCWM activities. The PCU will serve as the secretariat of the SMC for the purposes of the project only and will produce brief progress reports that will be shared widely within the Ministry, its agencies, and key stakeholders, and which will be submitted to the Bank within one month after the end of each calendar semester. Short- or long-term technical support will be provided as may be required during implementation with the objective of building capacity within the Ministry and its technical counterparts. The PCU will report to the General Secretary, who is the signing authority of the project. The establishment of the PCU and selection of its staff with qualifications and experience satisfactory to the World Bank no later than 30 days from project effectiveness is a legal covenant.
5. Other key agencies which will have an important role during project implementation are as follows:
 - The Ministry of Finance, Labor and Transfers (MoFLT) is responsible for allocation of resources to the sector and oversight of the budget execution. The MoFLT supports reforms that can potentially increase efficiency in spending while incentivizing increased quality of care.
 - The HIF is an executive Agency of the MoH and will be responsible for implementation of the Health Insurance Law. The HIF is key agency responsible for the implementation of technical activities related to mandatory health



insurance and purchasing reforms. The HIF will also be authorized with contracting and purchasing from the list of health care services and list of drugs and medical consumables material from health institutions licensed in all forms of ownership. It also has the right to pool all financial means for this purpose. The HIF is also responsible for setting performance stimulation scheme for health professionals and relevant professional services at all three levels of health care, based on objective and transparent criteria to meet the volume and quality indicators of health care services provided by sub-legal acts issued by the MoFLT.

- Municipalities are responsible for primary care service delivery. The Municipalities, through their Main Family Medicine Centers, will be responsible for collecting and reporting HIS data.
6. More details on the project's institutional and implementation arrangements will be set out in a POM, to be approved by the MoH within 30 days after project effectiveness. The POM will clearly describe the roles, responsibilities, and processes during project implementation.



Table 1.1. Implementation responsibilities by components

#	Component	Coordinating Unit	Implementing Units	Other structures involved
Component 1. Strengthening key health system building blocks for QoC				
1.1	Improving service delivery Strengthening capacity for public health and PPR	MoH Strategic Department, Health Inspectorate, NIPH, PHC division, PHC representatives	MoH	Municipalities
1.2	Developing and implementing strategic purchasing for quality	HIF	MoH	
1.3	Strengthening institutional capacity for public health and PPR	NIPH, HCWM Division	MoH	
Component 2. Developing an IHIS				
2.1	Establishing foundational building blocks of IHIS	eHealth Body/DHSC, HIS Department	MoH	
2.2	Digital health support for improvement in QoC	eHealth Body/DHSC, HIS Department	MoH	PHCs, KHUCs, Regional Hospitals
2.3	Implementation of IHIS strategic systems	eHealth Body/DHSC, HIS Department	MoH	
Component 3. Project Management, Monitoring, and Evaluation				

Table 1.2. Implementation Support Plan Period

Period	Focus	Skills needed	Staff weeks (annual)
Years 1-2	Overall technical and operational support	Task Team Leaders	20
		Operations Officer	
	Implementation of QoC activities	Health/HD specialist	2
	Plans, implementation and monitoring for HCWM activities	ESF Specialist	2
	Implementation of PPR activities	Health Specialist	2
	Implementation of HIS activities	HIS Specialist	4
	FM	FM Specialist	2
	Procurement	Procurement Specialist	2
	Environmental risk management	Environmental Specialist	2
Years 3-6	Overall technical and operational support	Task Team Leaders	20
		Operations Officer	
	Implementation of QoC activities	Health/HD specialist	3
	Plans, implementation and monitoring for HCWM activities	ESF Specialist	2
	Implementation of PPR activities	Health Specialist	2
	Implementation of HIS activities	HIS Specialist	5
	FM	FM Specialist	2
	Procurement	Procurement Specialist	2
	Environmental risk management	Environmental Specialist	2



ANNEX 2: Detailed Project Costing (US\$)

	Total cost	IDA	Gov't
1. Strengthening key health system building blocks for QOC			
1.1 Improving service delivery	1,409,200	1,409,200	-
1.1.1. Annual National District and National Health Forum (Formalized citizen engagement and empowerment)	60,000	60,000	-
1.1.1a Annual National District and National Health Forum (Formalized citizen engagement and empowerment)	60,000	60,000	-
1.1.2. Clinical Guidelines/Protocols/Pathways	249,200	249,200	-
1.1.2a TA on strengthening institutional processes for development of new clinical guidelines	39,200	39,200	-
1.1.2b TA on development of clinical care pathways (to be selected during implementation)	210,000	210,000	-
1.1.3. Quality Monitoring, Clinical Audit and Feedback	106,040	106,040	-
1.1.3a Development of quality indicators, clinical audit and feedback manual for quality coordinators	106,040	106,040	-
1.1.4. Capacity building for QoC interventions	480,000	480,000	-
1.1.4a Consultant for curriculum design and TOT	80,000	80,000	-
1.1.4b Training of providers on clinical care pathways/protocols/guidelines, clinical audits, best QA/QM practices	300,000	300,000	-
1.1.4c Support the functionalization of the QoC unit within NIPH/MOH/KHUCS	100,000	100,000	-
1.1.5. Strengthening Health Inspectorate	513,960	513,960	-
1.1.5a Equipment and supplies for e-inspections	245,960	245,960	-
1.1.5b Developing/Standardizing quality and safety standards and work plans	138,000	138,000	-
1.1.5c Training and capacity building for health inspectorate	130,000	130,000	-
1.2 Developing and implementing strategic purchasing for quality	320,000	320,000	-
1.2.1. Capacity building on strategic purchasing	320,000	320,000	-
1.2.1a BBP development, including ODBP implementation guidance	120,000	120,000	-
1.2.1b Provider payments and incentive systems, including options for adjusting capitation-based performance payment	120,000	120,000	-
1.2.1c Options for including the private sector and controlling costs of treatment abroad	80,000	80,000	-
1.3 Strengthening capacity for public health and PPR	5,221,600	5,221,600	-
1.3.1. Equipment and supplies for AMR and IPC	395,000	395,000	-
1.3.1a Capital investments (equipment/supplies)	190,000	190,000	-
1.3.1b Educational material and media purchases for AMR Awareness	45,000	45,000	-
1.3.1c Supplies for AMR and HAI Surveillance	40,000	40,000	-
1.3.1d Capacity building for Antimicrobial Stewardship in Hospitals	20,000	20,000	-
1.3.1e Equipment for Infection Prevention and Control	100,000	100,000	-
1.3.2. Training in IPC, AMR, and HCWM	130,000	130,000	-



1.3.2a Training in IPC, AMR and HCWM	130,000	130,000	-
1.3.3. Health care waste management	4,696,600	4,696,600	-
1.3.3a Provision of standardized protective equipment and medical waste collection	165,000	165,000	-
1.3.3b Construction/adaptation of safe storage spaces (warehouses) for infectious and sharp waste	1,352,800	1,352,800	-
1.3.3c Construction/renovation of follow-up infrastructure for treatment of MW	572,000	572,000	-
1.3.3d Replacement of outdated equipment (Autoclaves) for MW treatment	1,657,600	1,657,600	-
1.3.3e Procurement of transport vehicles for MW	517,200	517,200	-
1.3.3f Drafting detailed architectural plan for central warehouse of pharmaceutical waste	32,000	32,000	-
1.3.3g Renovation of the central warehouse of pharmaceutical waste and monitoring of works	400,000	400,000	-
Component 1 Total	6,950,800	6,950,800	-
2. Developing an IHIS to monitor and improve care			
2.1 Establishing foundational building blocks of IHIS	4,600,000	4,600,000	-
A1.01 Review legal framework for IHIS and draft legal/regulatory texts	100,000	100,000	-
A1.02 Support establishment of eHealth Body	200,000	200,000	-
A1.03 Hire consulting company to guide initial implementation	900,000	900,000	-
A1.04 Master Data Management - assessment/design and investment in system	500,000	500,000	-
A1.05 Health Information Exchange (assessment/design and investment in system)	1,200,000	1,200,000	-
A1.06 Procure hardware for IHIS building blocks	800,000	800,000	-
A1.07 Systems training of relevant health personnel	700,000	700,000	-
A1.08 Training of IT administrators and technicians	200,000	200,000	-
2.2 Digital health support for improvement in QOC	970,000	970,000	-
A2.01 Full roll-out of BHIS/infrastructure, printers, etc.	350,000	350,000	-
A2.02 Institutionalize and automatize update of key registries/codes in BHIS	80,000	80,000	-
A2.03 Allow BHIS reporting/business intelligence at facility level	120,000	120,000	-
A2.04 Embed clinical guidelines/pathways into BHIS	150,000	150,000	-
A2.05 Finalize patient empanelment/zoning and update BHIS database	100,000	100,000	-
A2.06 Upgrade e-referral and introduce e-appointment to BHIS	120,000	120,000	-
A2.07 Develop quality-of-care dashboard for PHC facilities within BHIS	50,000	50,000	-
2.3 Implementation of IHIS strategic systems	9,430,000	6,630,000	2,800,000
A3.01 Central electronic health records (design and implementation)	1,200,000	-	1,200,000
A3.02 HMIS (Hospital MIS) design and implementation	5,000,000	5,000,000	-
A3.03 Central LIS (Laboratory IS), design and implementation	800,000	800,000	-
A3.04 RIS (Radiology IS) including PACS (Picture Archiving and Communication Systems)	-	-	-



<i>A3.05 Upgrade to the Pharmaceutical Stock Management System</i>	200,000	-	200,000
<i>A3.06 Blood Transfusion information system, connecting regional transfusion center</i>	600,000	-	600,000
<i>A3.07 Patient portal (to access personal health record) (to use e-Kosovo - through Agency for Information Society)</i>	500,000	-	500,000
<i>A3.08 NIPH health data analytics - data warehouse, data transfer interfaces, smart reporting (including NCD, Cancer and screening registries)</i>	600,000	600,000	-
<i>A3.09 Upgrade of early warning and surveillance system of communicable diseases (main system financed through existing project)</i>	100,000	100,000	-
<i>A3.10 E-prescription, track and trace</i>	300,000	-	300,000
<i>A3.11 E-inspection module</i>	130,000	130,000	-
Component 2 Total	15,000,000	12,200,000	2,800,000
3. Project Management, Monitoring, and Evaluation			
<i>3.1.1. Project management staff</i>	505,000	505,000	-
<i>3.1.2. Project operations</i>	244,200	244,200	-
<i>3.1.3. Developing M&E framework and surveys for M&E</i>	100,000	100,000	-
Component 3 Total	849,200	849,200	-
Grand Total	22,800,000	20,000,000	2,800,000



ANNEX 3: Fiduciary Arrangements

Financial Management

- 1. Country issues.** The project will rely extensively on the various elements of Kosovo's PFM systems: planning and budgeting, internal control, flow of funds and payments, accounting and reporting, and external audit. Latest PFM reviews⁵⁷ have plotted the remarkable progress Kosovo has made in improving its PFM. The key strengths of the system are the sound legal framework, the integrated central treasury system, a budget classification system that is consistent with international standards, and an increasingly effective external audit office. The strengths of the system are offset by limited professional and technical capacities across budget organizations and gaps in implementation. Despite progress, several elements have room for further improvement. These include improving the quality and coordination for budget planning for capital investments, strengthening control framework, improving quality of internal audits, and enhancing capital investment management.
- 2. FM capacity.** Project FM is the responsibility of the MoH's Finance and Budget Department. The department is adequately staffed, staff have clear and appropriately defined roles, and the PFM legislation in place. In previous projects, this unit was supported by an external FM Specialist, to address increased workload on existing staff time and skills gap. Similar arrangements will be adopted for the project as the same gaps are noted.
- 3. Planning and budgeting.** In general, the mechanisms for budgeting and release of funds in budget organizations are considered adequate for the needs of the project. Project budgets would be based on annual project workplans compiled by technical departments and approved by project management. MoH is required to implement an effective and documented project planning, procurement planning and contract monitoring process. These budgets would form the basis for allocating funds to project activities and, after expenditures are paid, for requesting reimbursement from the Bank. Usually, in the Annual Budget Law, the project expenditure will be provided under foreign finance source code for (i) goods, non-consulting services, and works, which fall under capital expenditure, and (ii) consultant services, training and operating costs, which fall under goods and services budget category. Annual budgetary ceilings imposed on MoH programs may limit the level of annual project spending, especially for those items that are not regulated by the investment clause. To mitigate the risk pertaining to insufficient or untimely budget planning, MoH management should proactively steer the project planning process, ensure realistic forecasts are produced and included in the medium-term expenditure framework and the Annual Budget Law. In addition, the World Bank team will review the annual work plan and follow up on budget formulation process.
- 4. Accounting and financial reports.** The MoH will maintain project financial records (budget appropriations, allocations, commitments, and actual expenditure) following the Kosovo FM Information System (KFMIS) Chart of Accounts and identified by the unique project code. The KFMIS can generate project reports by the nature of expenditure, institution, source of fund and program. The drawback is that existing KFMIS reporting arrangements cannot track project expenditure by activity. Therefore, the project unit will prepare and maintain, in addition, a spreadsheet-based reporting that will be reconciled periodically with KFMIS. The IFRs will be submitted on a quarterly basis to the World Bank within 45 days after the end of each quarter. The FM Specialist will be responsible for the preparation of the project's periodic financial reports annual financial statements based on the financial information registered in the KFMIS. The IFRs will contain at least the following: (i) statement of sources and uses of funds (with expenditure classified by disbursement category); (ii) statements of sources and uses of funds (with expenditure classified by component/activity); (iii) contract monitoring; and (iv) KFMIS budget execution reports. Annual project financial

⁵⁷ Kosovo has participated in a number of detailed reviews of its PFM systems, such as several Central Government and municipal Public Expenditure and Financial Accountability assessments, annual reviews, and other analyses by the World Bank and International Monetary Fund. Latest national Public Expenditure and Financial Accountability assessment was dated 2022.



statements would be prepared based on International Public Sector Accounting Standards cash basis. The financial statements would cover the government's fiscal year. The first financial reporting period will be determined by the time when payments for eligible expenditure will initiate. The functional and reporting currency is Euro.

5. **Internal control.** For the project, the MoH is committed to maintain an effective internal control system, which will be strengthened with additional control activities and procedures depicted in POM. The existing system ensures, to a certain extent, that project expenditures are properly verified and authorized; supporting documents are maintained; accounts are reconciled periodically; and project assets, including cash, are safeguarded. There have been some internal control issues reported by the audits over the past four years, as follows: (i) project auditors raised certain issues with the payment/acceptance evidence which were eventually resolved; and (ii) MoH auditors indicate that compliance with the financial rules is not always consistent, such as with the commitment controls, misclassification of expenditure, and recording of assets.⁵⁸ In this regard, the POM will include among other things: (i) the organization of the FM, functions, staffing and respective roles and responsibilities; (ii) the necessary templates for recording, monitoring, and reporting various transactions; (iii) strengthened internal controls and documentation requirements; (iv) disbursement procedures; (v) project planning and budgeting procedures; and (vi) project reporting and auditing.
6. **Audit.** The project's financial statements, as described above, would be audited annually by Kosovo's National Audit Office, under terms of reference acceptable to the World Bank. In case the National Audit Office would withdraw from engagement, the audits of the project financial statements would be conducted by private auditors acceptable to the World Bank and the audit fees would be financed from project resources. The annual audited Project Financial Statements, together with the Management Letter, will be submitted to the World Bank no later than six months after the end of each fiscal (calendar) year.
7. **FM implementation support and supervision plan.** The World Bank team will supervise the project's FM arrangements by: (i) reviewing the project's IFRs and the annual audited financial statements and auditor's management recommendation letters; and (ii) performing on-site supervision combined with virtual reviews at a frequency based on the project's risk and performance. As with technical oversight and support, the World Bank fiduciary team will provide intense support at two points during project implementation: during the first year of implementation and at midterm.
8. **Disbursement.** Disbursements under the project will be carried out in line with the World Bank Disbursement Guidelines. The project activities will be wholly financed by the IDA financing. The project funds will be disbursed through traditional IPF disbursement methods. The Government of Kosovo's preferred method of disbursement is reimbursement of funds pre-financed from the government budget to finance project expenditures. The advance and designated accounts may be used for the project, on the Treasury discretion. In that case, a DA denominated in euros will be opened and maintained in the Central Bank of Kosovo, as a subaccount linked to the Single Treasury Account. The advanced funds will be based on 6-months spending forecast and be earmarked for the project. MoH will initiate requests for disbursement. The disbursement procedures, including paths for authorization of withdrawals, will be described in detail in the FM section of the POM. Authorized signatories will consist of the MoFLT and MoH officials. A detailed Disbursement and Financial Information Letter (DFIL) explaining all arrangements will be issued and will include the minimum application size for withdrawal applications, the ceiling of the DA balance, documentation requirements, and the frequency of application. The DA ceiling and minimum amount for direct payments will be flexible, based on the six-month forecast.

⁵⁸ MoH Regularity audit report issued by National Audit Office for the year 2022.



9. **Documentation of expenditure.** Eligible expenditures will be documented by Statements of Expenditures for advance, reimbursement, and by invoices for direct payments. The Statements of Expenditure will follow the templates provided in the DFIL. If a DA is used, the bank statement will be required to document the account balance. For direct payments, the World Bank will require copies of the original documents evidencing eligible expenditures in the form and substance specified in the DFIL. Records include documents such as invoices and receipts. The MoH is required to maintain original documents evidencing eligible expenditures, making them available for audit or inspection. These documents should be maintained for at least two years after the World Bank receives the audit report and for the period required by local legislation.

Procurement

10. Procurement will be carried out in accordance with the following World Bank procedures: The World Bank Procurement Regulations for IPF Borrowers, fourth edition, dated September 2023; Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants, dated October 15, 2006, and revised in January 2011 and Anti-Corruption Guidelines as of July 1, 2016; and other provisions stipulated in the Financing Agreements. The World Bank's Standard Procurement Documents will govern the procurement of World Bank-financed Open International Competitive Procurement. Mandatory Procurement Prior Review Thresholds detailed in Annex I of the Bank's Procurement Procedure are observed. For bidding processes with a national market approach, bidding and requesting quotations documents will use standard procurement documents acceptable to the World Bank. These will be included in the POM. The project will use the Systematic Tracking of Exchanges in Procurement system.
11. The PCU will facilitate the implementation of the project, and will include key positions like Project Coordinator, Procurement Specialist, and FM specialist. The World Bank Team determined that the procurement capacity is adequate to implement the new project. The PCU will be responsible for all project procurement activities and act as a Secretariat to the SMC.
12. The procurement assessment concluded that there are risks associated with the following:
- the complexities of procuring IT systems and hardware, plus in a sector with many INT cases in the region;
 - supervision and management of the implementation of various IT systems;
 - coordination between relevant stakeholders and potential risks in complex inter-institutional arrangements; and
 - high rotation of Procurement Specialists due to low salaries and increased demand from other donors.
13. To mitigate the identified risks, it is suggested to carry out an action plan that includes:
- hiring additional technical staff to support the PCU on technical matters;
 - defining in the POM the appropriate roles and responsibilities of the technical and procurement units;
 - defining in the POM the roles, responsibilities, and functions, including the interaction between the different stakeholders;
 - providing the PCU with a solid capacity to design, evaluate, and manage the implementation and integration of IT systems; and
 - ensuring that the World Bank continues to provide training and workshops in World Bank Procurement regulations to increase the pool of potential procurement specialists.
14. The MoH should set up an evaluation committee to evaluate bids/proposals on time. Moreover, the PCU and the respective agency will ensure that the committee members have solid knowledge in the field of the assignment.



ANNEX 4: Economic Analysis

1. **The economic and fiscal analyses carried out during the preparation of the project covered: (i) an estimation of the project’s development impact in terms of expected benefits and costs; (ii) the rationale for public involvement; and (iii) the World Bank’s contribution to the project.**

Estimation of Project’s Development Impact

2. **There is a strong economic case for investing in PPR.** Preventing and controlling disease outbreaks yields large economic benefits by reducing the threats of epidemics and pandemics beyond the health benefits of reducing the number of infections, reducing mortality, morbidity, and health care costs. Disease outbreaks affect economic activity by decreasing demand on one hand due to the drastic decrease in personal income, accompanied with a fall in investment and exports fall, and decreasing supply on the other hand due to the decrease in agriculture production and the closure of businesses in many sectors. This is in addition to the reduced labor, capital, and productivity, which are the major components of growth.⁵⁹ Globally, the economic impacts of severe pandemics have been estimated at 4.8 percent of global GDP or approximately US\$3 trillion in the 21st century.⁶⁰

3. **Evidence highlights that the return on investment of PPR may show large variations depending on the type of pathogen, the affected country, its demographics, and the mitigation strategies applied.** For instance, recent study shows that the return on investment of PPR in terms of value-of-life-years-lost averted per US\$ 1 spent ranges between US\$ 34 – 1,703 for a COVID-like pandemic, US\$ 42 – 968 for a SARS-like pandemic, and US\$ 4 – 415 for a Spanish-flu-like pandemic, i.e., the more severe the pandemic, the higher the return on investment. Moreover, the same study shows that the net benefits of PPR in terms of GDP loss averted ranges from 0 to 12 percent of GDP.⁶¹

4. **The project’s aggregate development impact will primarily stem from strengthening Kosovo’s capacity to prevent, detect and respond to future epidemics and public health risks, and from strengthening the service delivery systems and investing in primary health care, digital technology, and data together with building capacities of healthcare workforce.** Each of these factors is expected to have an economic impact through several channels.

5. **The primary direct impact of epidemics is their interference with the basic economic processes of production and trade and the devastation of human capital.** Evidence shows that global losses due to COVID-19 pandemic were estimated at between 5.5 and 8.7 percent of world GDP in 2020 and 3.6 and 6.3 percent of world GDP in 2021.⁶² These impacts largely originate from declines in domestic demand and tourism, and from global spillovers. For instance, evidence shows that Kosovo’s economy was heavily affected by the COVID-19 crisis. In 2020, Kosovo’s economy recorded a contraction of 6.9 percent, mainly due to declines in consumption, especially diaspora-related exports of travel services and investments.⁶³

6. **Secondary effects, such as additional losses of human capital occur through the outbreaks’ interference with basic public service functions such as health and education system functions.** For example, the COVID-19 pandemic and resultant chaos created a climate of fear and contributed to the unprecedented scale of disruptions of delivery and uptake of immunization services. Specifically, 23 million children around the world missed out on basic vaccines through routine

⁵⁹ UNDP. 2014. Assessing the Socio-Economic Impacts of Ebola Virus Disease in Guinea, Liberia, and Sierra Leone: The Road to Recovery. New York: UNDP.

⁶⁰ World Bank. 2013. Background Paper on Pandemic Risk for the World Development Report. “A single severe flu pandemic could cost US\$3 trillion. It is hard to imagine a more severe threat to ending absolute poverty or to boosting shared prosperity in developing countries”.

⁶¹ Center For Global Development. 2023. What is the Return on Investment of Pandemic Preparedness? Center For Global Development | Ideas to Action.

⁶² Sawada Y. 2021. Macroeconomic impact of covid-19 in developing Asia. 1251.

⁶³ World Bank (2021), *Western Balkans Regular Economic Report: Subdued Recovery No. 19*, World Bank Group, Washington, D.C.



immunization services in 2020 – 3.7 million more than in 2019 – according to official data published by WHO and UNICEF.⁶⁴ Available literature highlights different factors that affected immunization coverage during the pandemic including vaccine and health workforce availability, concerns of exposure to COVID-19 infection, and restrictions of movements due to lockdowns.⁶⁵ Moreover, the pandemic has already had negative impacts on the continuity of health services whose implied costs in terms of morbidity and mortality are non-negligible. As for schooling, the COVID-19 pandemic led to physical school closures and a transition to online learning. While such closures were common across the world, their duration was different across and within countries. Evidence from research carried out in the first stages of the pandemic pointed to negative results, rising inequalities, and potential long-term gaps in learning. Moreover, multiple studies found evidence of an increase in the attainment gap between students from different socioeconomic backgrounds, differences in results between public and private schools, and that children from lower socioeconomic backgrounds had fewer opportunities to engage in learning activities.⁶⁶ Therefore, it is safe to conclude that containing outbreaks before they turn into pandemics has tremendous positive externalities at the global level.

7. **Improving the access to and quality of primary health care services**—for example, through ensuring the provision of vaccines, basic healthcare products, and NCDs prevention and control—leads to reductions in morbidity, mortality, and improvements in financial protection. Essential and affordable care that is widely accessible is a fundamental component in building and maintaining human capital, which contributes to a population’s productivity, and manifests in economic growth. In terms of direct costs and benefits of primary healthcare services, there is evidence that increased investment in primary care can reduce use of both secondary and tertiary care and reduce overall health costs,⁶⁷ represented in decrease in funds spent on hospitalizations, prescriptions, and common tests and procedures.⁶⁸ Evidence also suggests that primary care can improve population health in terms of life expectancy and maternal, infant, and neonatal mortality.⁶⁹ Finally, there is evidence of large economic benefit from the combination of strengthening PPR and primary health care services. For example, the return on investment from childhood immunizations in lower-middle-income countries has been estimated as US\$44 for each US\$1 spent.⁷⁰

8. **Actions on strengthening capacities of health workforce, digital technology and data will improve service delivery and enable the population to access better health services in a timely manner.** As the health workforce will be strengthened through the project interventions enabling the population access better care, which will result in a decrease of mortality and morbidity. Additionally, investing in the enhancement of digital health systems will enable the early detection of and response to health emergencies.

Estimation of Project’s Impact on AMR

9. The assumptions used in the cost-benefit analysis are listed in Table 4.1 below:

Table 4.1. Assumptions Guiding the Cost-Benefit Analysis

Discount Rate	The monetary value of the annual DALYs saved is discounted at 3 percent , per the guidelines from the WHO and the Disease Control Priorities Project. ⁷¹ The higher rate of 5 percent is used for the sensitivity analysis.
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⁶⁴ WHO. 2021. COVID-19 Pandemic Leads to Major Backsliding on Childhood Vaccinations

⁶⁵ Lassi ZS, Naseem R, Salam RA, Siddiqui F, & Das JK. 2021. The impact of the covid-19 pandemic on immunization campaigns and programs: A systematic review. *International Journal of Environmental Research and Public Health*, 18(3), 988.

⁶⁶ European Commission. 2022. Impacts of COVID-19 on School Education. Publications Office of the European Union.

⁶⁷ E.g. Friedberg MW, Hussey PS, Schneider EC. 2010. “Primary Care: A Critical Review of the Evidence on Quality and Costs of Health Care.” *Health Aff (Millwood)* (29): 766–72.

⁶⁸ Harrold LR, Field TS, Gurwitz JH. 1999. “Knowledge, patterns of care, and outcomes of care for generalists and specialists.” *J Gen Intern Med.* (14): 499–511.

⁶⁹ Perry HB, Rassekh BM, Gupta S, Freeman PA. 2017. “Comprehensive review of the evidence regarding the effectiveness of community-based primary health care in improving maternal, neonatal and child health: 7. shared characteristics of projects with evidence of long-term mortality impact.” *J Glob Health.*

⁷⁰ Ozawa S, Clark S, Portnoy A, Grewal S, Brenzel L, Walker DG. 2016. “Return on investment from childhood immunization in low- and middle-income countries, 2011–20.” *Health Aff (Millwood)* (35): 199–207.

⁷¹ See DCP Project, “Disease Control Priorities in Developing Countries” (Seattle: Disease Control Priorities Project, 2006), <http://www.dcp2.org/>.



Time Period	The cost-benefits of each intervention are calculated over the period of 2023 – 2040 .
Population Covered	Even if interventions could be implemented nationwide, it is assumed that only 50 percent of the population would receive the interventions by the end of the project. Therefore, the interventions are expected to affect an average of 845,367 people by 2040. Population growth calculation is based on UN population projections (medium fertility) as a whole. ⁷²
Effectiveness Rate	The analysis is applying a conservative rate of 40% to calculate the effectiveness of IPC measures on AMR.

10. The benefits deriving from project interventions are estimated using the impact on population health status measured in term of DALYs, which represent the sum of years of potential life lost due to premature mortality and the years of productive life lost due to disability. The baseline DALYs were calculated for the various conditions from the Global Burden of Disease 2019 study estimates for Central Europe, Eastern Europe, and Central Asia and adjusted for the population size of Kosovo’s population. These include the forward projections of DALYs averted (that is, healthy life years gained) from 2023 to 2040.

11. DALYs were calculated using a very simple rule. Each DALY saved is valued at per capita income (using a starting value of about US\$ 5,351.4 for 2022). An upper, but still conservative, estimate values each year of life as three times per capita income, as per the Disease Control Priorities Project and the Copenhagen Consensus guidelines (Jamison, Jha, and Bloom 2008). Studies of the valuation of life in the United States utilize much higher values that would produce more extreme results.

12. Discount Rates for DALYs: The monetary value of the future stream of health benefits (i.e., annual DALYs saved) is discounted at three percent (with an upper sensitivity analysis of five percent), per guidelines from WHO and the Disease Control Priorities Project.⁷³ The overall results of the economic analyses by using impact of the project on AMR are presented in Table 4.2. It is worth mentioning that the project includes additional interventions that contribute to the control of NCDs, investing in health financing and digital health that are not yet captured in this analysis, which proves that the project is expected to yield high cost-benefit ratio.

Table 4.2. Net Present Value, Internal Rate of Return and Benefit-Cost Ratio of Project IPC Interventions

	DALYs Cost = GDP Per Capita	DALYs Cost = 3 * GDP Per Capita
Discount Rate = 3%		
Net Present Value	\$ 58,396,295.59	\$ 211,826,544.25
Internal Rate of Return	74%	390%
Benefit cots Ratio	\$ 4.19	\$ 12.56
Discount Rate = 5%		
Net Present Value	\$ 48,068,275.41	\$ 178,840,639.58
Internal Rate of Return	74%	390%
Benefit-Cost Ratio	\$ 3.78	\$ 11.33

The Rationale for Public Involvement

13. **Public sector interventions are justified from an economic perspective if market failures exist and there are interventions that correct them without imposing costs on society that exceed the benefits.** Examples of market failures include:

(a) **The presence of externalities.** When external costs or benefits are not automatically factored into the choices of individuals, this results in costs higher than the anticipated benefits. During pandemics and health shocks there are

⁷² See United Nations, Population Division, <http://www.un.org/esa/population/>.

⁷³ See DCP Project, “Disease Control Priorities in Developing Countries.”



always negative externalities, which is clear a market failure that justifies in principle a public-policy intervention with the aim of improving social welfare.

- (b) ***Insufficient and asymmetric information.*** During pandemics and health shocks people do not usually have access to all the relevant information in a timely manner, where access to information is affected by different variables such as socioeconomic status, education, and other variables. Imperfect information is common where the health effects of an intervention are insufficiently understood and researched (for example, because of the long-time lag between an intervention and outcome) and where industry’s marketing efforts distort information, intentionally or otherwise. Overall, government intervention in the form of the provision and production of health information is in principle justifiable, as information is a public good, which leads to its undersupply in the absence of government intervention.
- (c) ***Time-inconsistent preferences or “internalities.”*** In some situations, individuals give in to the temptation to accept immediate gratification at the expense of their long-term best interests. The solution to time-inconsistent preferences is to provide individuals with effective commitment devices. Given their enforcement power, governments are generally in a good position to invest in preparing for pandemics and strengthening the resilience of the health systems, especially when it is not common that individuals would choose to invest in preparing for pandemics.

13. **In this context, governments need to step in to build a resilient health system that can deliver effective pandemic prevention, preparedness, and response.** This is expected to yield economic benefits by lowering health sector costs and improving the health of the population in the form of a significant reduction in disabilities and premature mortalities while it addresses the three main forms of market failure mentioned above.

The World Bank’s Contribution to the project

14. **The World Bank brings substantial value added through its ability to draw from knowledge and operational track record on building resilient health systems.** The World Bank has extensive experience working with countries to strengthen their health systems resilience and preparedness to respond to public health emergencies and threats. For instance, the World Bank responded to the health and economic impact of the COVID-19 and built in the necessary experience and high standards to enable further investment in health systems preparedness, through the dedicated COVID-19 response program, Multiphase Program Approach that served 79 countries to date.



ANNEX 5: Overview of climate-related actions

Activity	Climate-Related Action and how it will adapt to or mitigate against climate change
Component 1: Strengthening key health system building blocks for QoC (US\$ 6.95 million)	
Citizen feedback, including related to climate-change, through District and National Health Forums (1.1.1)	Citizen feedback through District and National Health forums (\$60,000) will inform further development and of climate-related policies and is critical for effective environmental health governance. The forums will include specific modules related to feedback on the patient-provider experience, citizen perceptions on QoC, and impact of climate-related events on citizen health. In the context of flood risk communication and air pollution, local engagement practices and mutual communication among residents are essential for enhancing the health response to climate change, particularly at the district level. Adaptation
Inclusion of climate-resilient measures into clinical care pathways and guidelines (1.1.2)	Analysis of upstream determinants of exposure and vulnerability and identification of climate-related factors, trends and exposure pathways to improve overall health outcomes (\$50,000). Adaptation
Capacity building of healthcare providers to respond to climate emergencies and disease outbreaks (1.1.4)	The training of healthcare providers (\$300,000) will have six modules, including one which will focus on climate preparedness and prevention measures to minimize increases in illnesses following extreme weather events such as floods and extreme temperatures that frequently occur in the country. Specific modules and materials will be developed. The climate module will include specific information on water and sanitation and infection prevention and control during floods, among others. Adaptation
Energy-efficient MW equipment (1.1.5, 1.3.1, 1.3.3)	The Project will procure energy-efficient medical, laboratory and waste management equipment (US\$2.17 million) in compliance with energy efficiency standards. Energy Star (or similar) efficiency standards will be used to assess equipment not covered by the law to enhance the GHG mitigation aspects of this. Procurement will prioritize locally available or externally transportable energy-efficient equipment, thus aiding greenhouse gas emissions reduction. Mitigation
Green facility infrastructure (1.3.3)	The Project will finance infrastructure works for the storage and treatment of infectious, medical and pharmaceutical waste (US\$ 2.32 million). Facility construction and improvements will incorporate climate adaptation measures, such as insulation of roofs and walls, to mitigate heat stress on workers. Minimum energy savings for heating/cooling after reconstruction will be 20 percent, but higher savings are expected. These actions will enhance resilience of the facilities to climate shocks. Mitigation
Component 2: Developing an IHIS (US\$ 12.2 million)	
Enhancement of digital health network and Leverage Health Information Exchange services to support public health in the context of climate change (2.1, 2.3)	Digitizing the healthcare network, including through investing in the foundational building blocks of IHIS (US\$3.4 million), as well as through implementation of IHIS strategic systems (US\$9.43 million) will enhance access to health data during climate shocks (e.g., during the floods and heat waves), improving reach in vulnerable areas. Enhancing the digital health network will ensure service continuity through the development of stronger and more adaptable digital health solutions for effectively monitoring and managing disease outbreaks. In addition, the establishment of the Health Information Exchange (US\$1.2 million) will allow for critical system interoperability, which will aid in monitoring the migration of disease due to climate change and better target patients at-risk for climate-related health events (heat stroke, etc.) for prevention and/or timely intervention, incorporate novel data for better understanding the effects of climate change on the population of Kosovo, and aid emergency medical services with change in patient profile and potential increase in patients due to climate-related events. The combined impact of the expanded digital healthcare network and the improved interoperability through the Health Information Exchange will facilitate real-time decision-making for health workers through effective data exchange and service coordination, enabling a more responsive and adaptive healthcare system to climate impacts. Adaptation
Component 3: Project Management, Monitoring, and Evaluation (US\$ 0.85 million)	
Monitoring and management of climate related aspects of the project	This component will monitor the Project’s climate mitigation and adaptation aspects and should be assessed at the same rate as the Project’s other climate activities. Adaptation and Mitigation