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Borrower(s)	GOVERNMENT OF KYRGYZSTAN
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1. Country and Sector Background

Health reform in the Kyrgyz Republic

Like most countries in the former Soviet Union, the Kyrgyz Republic embarked on transition in August 1991 with a health system poorly suited to its newly constrained fiscal realities and to the demands of a poor country with poor health indicators. The first few years of transition were dire: GDP contracted by 50 percent between 1992 and 1995, social expenditures declined dramatically, poverty rates increased from their already-high rate—a third of the country was described as having a "socially unacceptable standard of living" even in 1990—to well over 50 percent in 1995, and the country's historically free health services were rapidly transformed into a *de facto* fee-for-service system due to the rise of informal payments that reached 75 percent of aggregate health expenditure in 1996. Under an IMF-led austerity program with an emphasis on fiscal restraint and economic liberalization, signs of economic recovery began to emerge after 1995. At the same time, the government began a series of measures aimed at improving the efficiency of the public sector and establishing the government as a true policymaker rather than an implementer of policies defined, historically, in Moscow. Among these measures was the adoption of a health sector strategy known as "Manas" in 1994. Key goals of the Manas strategy were to redress imbalances in the health care delivery network and strengthen its orientation towards preventive and primary health care; to improve equity in resource allocation; and to address financial and non-financial constraints affecting the accessibility of health services. The program, designed to run for 10 years from 1994 to 2004, attracted substantial support from donors and was implemented with relatively few deviations from its original objectives. The Manas program was broadly successful. Key results included an increased share of primary care in overall health expenditure, from 7 percent in 1994 to 18 percent in 2004; improved equity in the utilization of outpatient and inpatient health services (see Annex 9); expanded coverage of primary health care based on the family medicine model, up to nearly 90 percent by 2005 (i.e. 100 percent of the insured population); a balancing of fixed and variable costs in hospital financing, with a shift away from large allocations for wages and utilities to increased allocations for medicines, medical supplies, equipment and other critical inputs; an increase in the share of health expenditure allocated to direct patient care, from 16.4 percent in 2000 to 36.6 percent in 2004; "rightsizing" of the health infrastructure and human resources, with bed numbers, staff numbers and

hospital buildings all reduced by 30 to 40 percent over the Manas period; and significant moves toward formalizing informal payments and improving transparency and accountability in the health sector (see Annex 9). The reforms underpinning these outcomes were varied and included a combination of reforms in health financing and payment systems—central to which was the establishment of a single-payer system centered on the Mandatory Health Insurance Fund in 1997—and efforts to reform the primary care network, train primary care providers and improve the efficiency and cost-effectiveness of pharmaceutical use, among many others.

The current situation and remaining challenges

The reforms stimulated by the Manas program took place against a complex background of fiscal irregularity, both for the budget as a whole and for the health sector specifically, and left a number of policy, institutional and other challenges yet to be resolved. These can be summarized as follows:

1. Optimal and timely allocation of funds for the health sector. With a large debt burden and irregular revenues—impacted significantly by the regional financial crisis in 1998 and slow growth in the years thereafter—budgetary allocations to the health sector experienced rapid and dramatic shifts that systematically undermined the ability of sector leadership to fulfill the objectives of "Manas" to the extent originally planned. Worse, budget financing for the health sector declined more than other sectors. From 1996 to 2004, public expenditure on health declined from 3 percent to 1.8 percent as a share of GDP, republican spending falling from 13 percent to 9 percent of total government expenditure and local government spending falling from 28 percent to 22 percent, also as a share of total government expenditure. Budget execution has been a serious problem and has repeatedly challenged the ability of the Mandatory Health Insurance Fund to meet contract commitments with providers; this in turn has led to the accumulation of *de facto* arrears to providers (and thence, suppliers) of around KGS 92 million (~US$ 2.3 million) by mid-2005. These are issues for the Ministry of Finance as much as the Ministry of Health; what is needed are efforts to strengthen the accuracy of budget planning, improve budget sustainability and reduce budgetary distortions that undermine the efficiency of sector management. The government is currently embarked on a series of public expenditure management reforms. Better budget formulation and execution and a move toward results-based monitoring are all envisaged; if realized, the impact of these reforms on the health sector could be substantial.

2. Intrasectoral allocations. These have improved over the past 10 years, with a larger share of health spending going to primary and preventive care, but there is room for improvement since almost 70 percent of government health expenditure in 2003 still went for inpatient care, down from 85 percent in 2001 (Policy Research Paper 30, WHO/DfID Health Policy Analysis Project, 2005). This is a significant share when compared with the OECD average of 38 percent going to inpatient care, especially considering the differences in age structure and epidemiological profile between the two. Allocations for public health and health promotion remain limited.

3. Inequalities in health spending, outcomes and MDG performance. There continue to be significant inequalities in both health spending and health outcomes. Regional inequalities in the allocation of public funds are still an issue: poor regions such as Batken and Naryn receive less public financing as compared with better-off regions such as Bishkek and Osh. Inequality in access to health services has improved as a result of the Manas program. Manas strengthened the primary care system and introduced the family medicine model of integrated "one stop shopping" for basic health care needs. These reforms, combined with the development of a financing system that mitigated financial barriers to care—since primary care is free, the incentive to bypass it has been reduced—and efforts to improve access to outpatient drugs, led to improvements in both access and quality of care and in turn to lower hospitalization rates for conditions such as hypertension, asthma and peptic ulcer disease.

Disparities in health outcomes persist by region, income and area of residence. For example: while IMR and U5MR have improved in the aggregate, they have actually *worsened* in a number of regions. Infant deaths are clustered in the neonatal and perinatal periods, raising concerns about the coverage and quality of safe motherhood and newborn health programs; and the Kyrgyz Republic still has among the highest rates of TB, including multi-drug resistant TB, in the Europe and Central Asia region. Rural households in particular continue to face demand- and supply-side barriers to accessing quality health services, including shortages of information, skilled health personnel, drugs and transport.

4. Public health and health promotion. The Manas program took several first steps toward reforming and strengthening public health and health promotion functions: historically among the most conservative parts of the ex-Soviet health system and the hardest to reform. A number of credible steps were taken, among them efforts to modernize disease surveillance system and to establish an independent Republican Center for Health Promotion. Health promotion was also integrated in the retraining curriculum of family medicine doctors. These efforts, notwithstanding, budgetary allocations to public health and health promotion remain low, key institutional issues remain unresolved, and investment requirements, e.g. in the laboratory network, remain substantial.

5. The Ministry of Health. The Manas program, with its appropriate emphasis on financing reforms, focused largely on strengthening the Mandatory Health Insurance Fund (MHIF), introducing the purchaser/provider split, decentralizing management responsibility to health care providers and building the capacity of providers themselves. These reforms modernized and improved performance in the health system and led to a fundamental change in the role and functions of the Ministry of Health from a provincial administrator of the network of Kyrgyz health facilities in 1990 to its current role as a "steward" and maker of sector policy. MOH is no longer the key purchaser of health services nor does it own the majority of health facilities in Kyrgyz Republic. Instead, its role now consists of the functions typically associated with a modern MOH: policy making, priority-setting, budget formulation linked to policy priorities and monitoring and evaluation. With these changes has come the need to formally streamline the roles and functions of the MOH and strengthen its ability to carry out its new—and more influential—mandates.

6. "Rightsizing" health infrastructure. Progress on this front in Manas was excellent. Progress in Bishkek and Osh cities was, however, more limited; and since the health infrastructure in these cities represents a large share of Kyrgyz Republic's total health infrastructure, further work is needed. The main instruments here include expansion of the single-payer system to cover these facilities, development of optimization plans and implementation of item-free financing methods that allows facilities to retain savings from restructuring and reallocate them to other inputs for service delivery.

Manas Taalimi

Manas Taalimi was developed in 2005 by the Ministry of Health as a successor to the Manas strategy and is an expansion of the health goals embedded in the National Poverty Reduction Strategy (NPRS) (2002) and Comprehensive Development Framework (CDF). It aims to institutionalize the reforms initiated under Manas I and to strengthen parts of the health system that were relatively less emphasized under Manas I. In particular, it seeks to strengthen the targeting of resources and interventions at groups with worse health outcomes, including MDG outcomes; implement structural improvements in the public health and health promotion systems; enhance capacity in the Ministry of Health and other relevant institutions in policy formulation, priority setting, policy-based budget planning and monitoring and evaluation; and strengthen quality of care with a focus on priority health problems including cardiovascular diseases, respiratory illnesses, HIV/AIDS and tuberculosis. The strategy was developed and refined through extensive stakeholder consultations. These included a traveling road show with

town-hall meetings throughout the country, consultations with senior officials in government, and numerous formal and information consultations with health sector donors. The process was led by the government—which gave a core team of health specialists from MOH, SES, MHIF and other key institutions extended leave to work on the strategy and provided re-entry guarantees to their original posts once the strategy was finished—and was carried out in an open, transparent manner with full inclusion of donor partners. From the outset it was envisaged that Manas Taalimi would be implemented in a Sector-Wide Approach, both to formalize the excellent informal donor coordination existing around Manas I and to include, if possible, donor support for financing of recurrent/operational costs and efforts to harmonize procedures and strengthen fiduciary systems in the health sector. Development of Manas Taalimi and the Sector-Wide Approach took place against a complex social and political background that included unexpected changes in senior MOH staff early in 2005, uprisings in March and June, the ousting of President Akaev, the restoration of political stability in July and subsequent reforms to the Kyrgyz government structure. These developments tested the Ministry's leadership of the reform process and the ability of the donor community to respond with a single voice—both of them preconditions for an effective sector-wide approach—and confirmed the readiness of the Kyrgyz health sector for a SWAp.

The Manas Taalimi strategy is accompanied by a five-year Program of Work, a five-year sector expenditure program and MTBF, and a panel of sector monitoring, including fiduciary, indicators. These will form the basis of donors' financial support, both for investment and recurrent costs, and efforts to monitoring sector performance.

Strengthening Social Protection Policies

The Kyrgyz Republic has made substantial progress in its transition to a market-based economy during the past decade. Despite this progress, living standards are low, with over 40 percent of the population below the poverty line, and the Kyrgyz economic recovery remains fragile. The previous government dealt with the economic and social challenges through a reform program developed under the National Poverty Reduction Strategy (NPRS) initiative, which was launched in connection with preparation of the Comprehensive Development Framework (CDF) in 1999. NPRS implementation was in the process of being re-enforced through the preparation of the second NPRS before the recent change in government. The key issue that the new government is expected to tackle is, therefore, setting the reform priorities to effectively address these issues and sequence the reform measures accordingly.

In spite of the economic growth for the last decade, number of poor people remained high in the Kyrgyz Republic. Poverty levels are relatively high by regional standards, though inequality is reasonably low. The government has made progress in the reduction of overall poverty over the period 2001-04 (from 48 percent to 39 percent) as measured by preliminary monetary indicators.[1]. Total poverty levels continue to fall in both rural and urban areas but poverty remains higher in rural areas (45.7 percent versus 31.5 percent), while high levels of poverty among people, particularly internal migrants, living in recently constructed settlements in urban suburbs are of concern.

Disaggregated data on poverty reveal two important developments. First, extreme poverty fell rapidly from 13.5 percent to 9.4 percent during 2001-04.[2] The MDG of reducing extreme poverty by half by 2015 appears achievable now. Second, the reduction in extreme poverty in 2003 was higher than the reduction in overall poverty, reflecting a slight improvement in the Gini coefficient (currently at 0.325).

[1] Poverty rates referred to in this section are based upon expenditures per capita and were received from the National Statistics Committee as of September 20, 2004. Results for 2003 are still preliminary and may be subject to further change.

2 Extreme poverty in urban areas fell from 12.0 percent to 5.0 percent in 2002-03 while rural poverty fell from 14.7 percent to 11.7 percent. These declines over one period are large, which may be a result of their preliminary status.

The Joint Staff Assessments for the NPRS (2003) and the Progress Report (2004) concluded that progress in NPRS implementation provides evidence of the country's commitment to reduce poverty. They also refer to areas where further progress is needed in NPRS implementation, including better prioritization of reforms, effective actions to address challenges in governance reforms and better links with annual budget/MTBF and MDGs.

The Bank is preparing a PRSG to support the government's poverty reduction and growth strategy in areas where the Bank has a comparative advantage, and where the sustainability of the key reforms requires consolidation, cross-cutting support and deepening to make a real progress in poverty reduction agenda.

- *Fostering economic growth and enhancing employment opportunities,* through key policy actions to improve the investment climate/governance and infrastructure services with a focus on regulatory reforms.
- *Improving efficiency and effectiveness of public resources* with a focus on strengthening public expenditure management and reforming intergovernmental fiscal system.
- *Strengthening social protection policies and their implementation* by consolidating benefit structure, and building a more efficient administrative system for implementing social assistance benefits; and by improving the pay-as-you-go pension system, and adopting a feasible, sequenced approach to a mandatory funded pension pillar.

The overall social protection objective of the policy-makers is to alleviate the most severe manifestations of poverty. Over the last two years several actions have been initiated in this regard: the levels of both pension benefits and unified monthly benefit (UMB) have increased in real terms; a decree has been issued to eliminate or cash out poorly targeted privileges for certain categorically eligible groups; social insurance collections performance has been improved significantly; arrears in payment of pensions and most benefits have been eliminated; and, energy-linked social protection benefits have been increased and streamlined.

Despite these efforts a series of unresolved social protection challenges remain including: (i) declining program funding compared to needs; (ii) poor targeting of privileged pricing for goods and services; (iii) inadequate energy-related social protection policies; (iv) lack of an implementation framework for social services; and, (v) faster growth of pension spending than of pension revenues.

2. Objectives

The objective of the Project is to support the implementation of the Manas Taalimi Program. The objective of the Manas Taalimi Program is, broadly, to "improve health status through the creation of an effective, comprehensive and integrated delivery system of individual and public health services, and through increased responsibility of every citizen, family, society, and public administration bodies for health of each person and for society as a whole." It encompasses a range of activities designed to improve access, financial protection, efficiency, equity, transparency, responsiveness and fiduciary performance in the Kyrgyz health sector. The Bank is in agreement with the main goals, objectives and priorities of the Manas Taalimi Program and the corresponding Program of Work (POW).

Monitoring & Evaluation: A panel of "dashboard" indicators will be used to monitor sector performance under the SWAp. The panel consists of indicators under the following headings: health status, access and equity, financial protection, efficiency, quality, responsiveness/transparency, and sector financing. For each dashboard indicator MOH will record the baseline value, confirm the frequency of monitoring and the institutions responsible for doing so, and set general targets for achievement by 2010.

3. Rationale for Bank Involvement

This would be the Bank's third project supporting the Kyrgyz health sector. The Health Sector Reform Project (P28600) ran from 1996 to 2001 and was rated highly satisfactory at completion. The Second Health Sector Reform Project (P051372) is implementing well and due to close in December 2005. Health is a key goal of the National Poverty Reduction Strategy. Health policy issues have featured in the recent GSAC/GTAC operation and social protection policy issues feature prominently in the PRSG currently under preparation. The proposed operation is included in the Kyrgyz Republic Country Assistance Strategy (CAS) for 2003-2006 in paragraphs 51 and 58. Key CAS goals supported by the Project include "stemming the deterioration in key infrastructure and social services"—where IDA's activities focus on supporting systemic changes to make service delivery more efficient as well as direct measures to provide for sustainable operations and maintenance of health infrastructure—and "addressing governance constraints to growth and poverty reduction," where priorities including increasing transparency and accountability in sector management and financing, building administrative capacity at national and local levels, supporting continued development of the NPRS and MTBF as vehicles for government planning and budgeting, and improving the informational basis for policy decisions in the Ministry of Labor and Social Protection.

In spite of progress in health reform and major gains in the efficiency of sector performance, the Kyrgyz Republic remains a poor country with weak health indicators and a continued need for investment and reform in the health sector. Rationales for Bank involvement include its long experience in the country and the sector, its successful record of supporting health reform, its experience with sector-wide approaches in other countries and its ability to draw connections across multiple sectors and reform areas—including health, public financial management, civil service reform and fiduciary functions, among others—that are of particular relevance when moving toward a sector-wide approach. In Labor and Social Protection, the Bank has a long history of involvement in policy dialogue through development policy operations such as GSAC/GTAC and the proposed PRSG. The present operation would provide modest investment financing to help improve information systems in MOLSP and thus to improve the timeliness and accuracy of decisions concerning targeting of social assistance and SP policy more generally.

4. Description

The lending instrument is a Specific Investment Loan (SIL), financed by an IDA Grant of up to US$15 million equivalent. In addition, a KfW Grant of €14 million, a DfID grant of £7 million and possibly further financing from SDC and SIDA are envisaged to contribute to joint financing of the SWAp. These funds would finance a share of MOH's annual development plans under the Manas Taalimi strategy and Program of Work, and separately, efforts to strengthen information systems in the Ministry of Labor and Social Protection. Expenditure for the health sector and contributions to Manas Taalimi will not be defined in detail as in a traditional World Bank investment operation, but IDA funds will flow to the Kyrgyz budget to finance a share of the combined GOK and external assistance budgets for the POW.

IDA funds for support to the Social Protection System and improving the targeting of benefits in contrast will be used as in traditional investment operations to finance two procurement packages: one for technical assistance and training and one for the procurement of goods.

5. Financing

Source:	($m.)
BORROWER	440.00
IDA Grant	15.00
KfW	20.00
DfID	13.00
Unidentified	652.00

6. Implementation

Overall responsibility for program management and implementation for the Manas Taalimi program lies with the Ministry of Health and its Department of Strategic Planning and Reform Implementation, and the MOH's adjunct organizations at the national and regional levels. MOH has a supervisory role in relation to all health-related organizations regardless of ownership and administrative level in the country. The proposed new structure of the MOH envisages a total of 64 staff, which is considered to be sufficient for the implementation of Manas Taalimi. The Mandatory Health Insurance Fund (MHIF) is a separate legal entity within MOH and is responsible for collecting and disbursing funds for health services covered by the State Guaranteed Package and the Outpatient Drug Benefit. Functional responsibilities for the eight components of Manas Taalimi have been identified, and will be allocated within appropriate organizational units in the Ministry of Health, as further detailed in Annex 6. Implementation responsibility for financial management tasks will be with the Deputy MOH/General Director of the HIF and the Economics and Finance Department of the Ministry of Health. A large amount of financial capacity building is necessary and it is planned that functions will be strengthened and integrated into this department over time. Some Manas Taalimi and SWAp financial management functions, particularly procurement of short-term consultants and training and technical specification for equipment, will be contained in the International Cooperation and Donor Coordination Unit. A Program Operational Manual (POM) will guide implementation and serve as a road map to all participating health sector institutions. The Social Protection component of the project would be implemented in collaboration between MOLSP and MOH.

7. Sustainability

The sustainability of Manas Taalimi and the IDA contribution will be determined by three things: first, the government's ownership of Manas Taalimi and the policy and investment priorities embedded therein; second, evidence of sufficient and progressively increasing budget financing for the health sector to target levels agreed between MOH, MOF and donors and enshrined in the MTBF; and third, the technical soundness of policy and investment choices embedded in Manas Taalimi. We consider these in the form of three questions:

③ Is Manas Taalimi "owned" by the government? Manas Taalimi was developed in a participatory process that involved representatives of several senior health sector institutions and was accompanied by a serious effort to ensure broad stakeholder consultation once the first draft came out. However, the period in which Manas Taalimi was developed was characterized by marked political instability—the worst since the Kyrgyz Republic's independence—and in spite of the relative stability *within* MOH and its efforts to ensure full comprehension of the program by the new government, final approval of the strategy would only have taken place after the government's establishment in October 2005 and would not have allowed sufficient time for the government to fully internalize the strategy and its implications. MOH mitigated this risk by keeping a wide range of stakeholders in the loop

while Manas Taalimi was being developed, and the new government's willingness to sign off on Manas Taalimi—and to provide its formal backing to the strategy—reflects to a large extent the effectiveness of these efforts. Further work will be required to strengthen ownership of the program by a progressively broader circle of stakeholders, including *inter alia* parliamentarians—historically skeptical of health reforms—the media, tertiary specialists and others. This will be assisted by improvements in the transparency of planning, budgeting, implementation, reporting, accounting, procurement, auditing and monitoring processes under the SWAp, and by the annual health sector performance reviews, external procurement and financial audits, and other consultation mechanisms associated with this approach.

- Will budget financing meet the sector's priority needs? This has been a problem in the past. The government is committed to increase health spending and recognizes the need to compensate for the significant decrease in health expenditure witnessed since the late 1990s. The NPRS and CDF set a target for health spending of 3.6 percent of GDP by 2010 and interpolate targets for 2006 to 2009. These targets have been incorporated in the government's 2006-08 MTBF and will form the basis of efforts to increase government health expenditure during the Manas Taalimi period. The willingness of donors to provide recurrent cost financing to help "bridge the gap" will help, but only to the extent that the government makes a good-faith effort to progressively increase its *own* health spending to levels anticipated in recent legislation on "minimum standards." It is acknowledged that the Kyrgyz Republic faces significant macroeconomic constraints; nonetheless, it is expected that budgets will, to the extent possible, reflect the government's stated objective under the CDF and NPRS to ensure sufficient budget financing of the sector to avoid *inter alia* the resurgence of informal payments and the departure of health staff for better-paying jobs elsewhere. Trends in government health expenditure vs. agreed targets will also be monitored closely under the SWAp.

- Will MOH make the right policy and investment choices? Two issues provide cause for cautious optimism on this front: first, the good performance of MOH under Manas I and the acknowledged efficiency and equity dividends arising from the Ministry's policy and reform choices under that program, as summarized in Annex 1; and second, that Manas Taalimi itself focuses on the "right" areas: namely, continuing pro-poor financing reforms, reforms to improve efficiency, equity and quality, and critical issues such as *inter alia* public health, priority health interventions and upgrading PHC infrastructure. Again, the collective scrutiny and consultative processes associated with a sector-wide approach will help MOH and its partners stay on a path that is consistent with the Manas Taalimi strategy.

8. Lessons Learned from Past Operations in the Country/Sector

A number of lessons were learned from Manas I and have been addressed both in the government's choice of a SWAp approach and in the content of the Manas Taalimi Program of Work itself. These include:

- Budget sustainability and the health sector. A key lesson from Manas I is that an unpredictable financing base and budget formulation and execution systems that are not synchronized with health reforms can be a significant barrier to implementation of reforms and reduce their beneficial impact. For example: rightsizing of health infrastructure is contingent on health providers retaining the saved funds and having the freedom to allocate these saved funds to achieve expected outcomes. Input-based budget formulation does not meet the needs of reforms aimed at rightsizing the health sector and reallocation of saved funds across functional categories. Significant progress has been made in identifying a legal framework for output-based budget formulation, and introducing item-free

financing for health providers. Nonetheless, these gains are still fragile and will need to be strengthened and sustained in the next phase of reforms. The level and predictability of financing for the health sector is an essential part of successful reform.

③ Focusing on core function of the Government. Health reform has changed MOH's role. With establishment of the MHIF and delegation of management to health providers, the MOH's role is now one of stewardship rather than hands-on management. Manas Taalimi reflects this by investing heavily in stewardship functions such as monitoring and evaluation and institutionalizing these activities into the routine operations of MOH.

③ Rightsizing the health sector: The implementation of the single payer system, specially the case based payments for hospitals, combined with optimization plans and item-free financing at the facility level is critical for rightsizing the hospital sector. If these policy instruments are not maintained, there is a risk that rightsizing in the health sector will not continue. This is of special concern in Bishkek and Osh cities, which between them have the majority of Kyrgyz Republic's stock of hospital capacity and where the rightsizing process remains incomplete.

③ Donor coordination. The success of Manas I can be attributed in part to outstanding donor coordination on reform issues. It frequently happened that one donor would support a pilot project, another would scale this up to the whole country, another would carry out monitoring and evaluation and another would provide technical assistance to draw policy lessons and have these incorporated in revised legislation. These collaborations were almost always informal and were enabled by a combination of policy consistency and leadership from MOH and a group of donors with the willingness and good-will to coordinate and cooperate independently. It was, however, recognized that this conjunction of favorable circumstances would not last forever; as such, an objective of the SWAp is to formalize these collaborations under an explicit definition of the government's policy and program directions—i.e. the Program of Work—and through periodic, formal, structured meetings for sector monitoring and donor coordination.

9. Safeguard Policies (including public consultation)

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment (OP/BP/GP 4.01)	[x]	[ ]
Natural Habitats (OP/BP 4.04)	[ ]	[x]
Pest Management (OP 4.09)	[ ]	[x]
Cultural Property (OPN 11.03, being revised as OP 4.11)	[ ]	[x]
Involuntary Resettlement (OP/BP 4.12)	[ ]	[x]
Indigenous Peoples (OD 4.20, being revised as OP 4.10)	[ ]	[x]
Forests (OP/BP 4.36)	[ ]	[x]
Safety of Dams (OP/BP 4.37)	[ ]	[x]
Projects in Disputed Areas (OP/BP/GP 7.60)*	[ ]	[x]
Projects on International Waterways (OP/BP/GP 7.50)	[ ]	[x]

10. List of Factual Technical Documents

Government of the Kyrgyz Republic. 2005. Environmental Management Plan for the Kyrgyz Republic Health and Social Protection SWAp.

* *By supporting the proposed project, the Bank does not intend to prejudice the final determination of the parties' claims on the disputed areas*

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