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Project Information Document (PID)

Appraisal Stage | Date Prepared/Updated: 20-Apr-2023 | Report No: PIDA34732

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Project Name	Parent Project ID (if any)
Tajikistan	P178831	Millati Solim: Tajikistan Healthy Nation Project	
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
EUROPE AND CENTRAL ASIA	10-Apr-2023	19-Sep-2023	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	Republic of Tajikistan	Ministry of Health and Social Protection	

Proposed Development Objective(s)

The objectives of the Project are to (i) improve the quality and efficiency of primary healthcare services in selected districts and pioneer regions, and (ii) strengthen the national capacity to respond to public health emergencies.

Components

Component 1 - Quality Improvements through Primary Healthcare Strengthening
Component 2 - Strategic Purchasing and Digitalization of PHC Services
Component 3 - Health Emergency Preparedness and Response
Component 4 – Project Management, Coordination, and Monitoring and Evaluation
Component 5 - Contingent Emergency Response Component (CERC)

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	57.25
Total Financing	57.25
of which IBRD/IDA	40.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	40.00
IDA Grant	40.00
Non-World Bank Group Financing	
Trust Funds	17.25
Global Financing Facility	12.50
Health Emergency Preparedness and Response Multi-Donor Trust	4.75

Environmental and Social Risk Classification

Moderate

Decision

The review did authorize the team to appraise and negotiate

Other Decision (as needed)

B. Introduction and Context

Country Context

1. **Tajikistan is a lower-middle-income International Development Association (IDA) member country in Central Asia with a large proportion of the population vulnerable to poverty and external economic shocks.** The country is landlocked with a population of 9.8 million.[1] Over the last decade (2012-21), the economy grew by a robust average rate of 7 percent per year.[2] Nevertheless, as of 2021, with a gross national income (GNI) per capita of US$1,150[3] Tajikistan remains the poorest country in the World Bank's Europe and Central Asia (ECA) region[4][5]. The economy is highly vulnerable to external shocks, relying heavily on primary commodity production and exports, with limited economic diversification and a substantive dependency on remittances (34 percent of GDP in 2021)[6], that primarily derive from Russia. Remittances are particularly important for the poorest households. While the country is projected to continue to grow at about 4 percent per year over the medium term, limited fiscal space will be further constrained by infrastructure-related spending planned over the next decade.[7] The country needs to broaden its tax base to increase critical investments in health, education, and social protection.[8]

2. **While the country has achieved sustained progress in reducing poverty, high population growth and low economic productivity continue to pose substantive challenges for poverty reduction and public service delivery.** The poverty rate fell from 32 percent in 2009 to an estimated 14.6 percent in 2021 (at the international poverty line of US$3.65 a day, 2017, PPP)[9]. Underemployment and informality (half of the labor force is informal[10]), low productivity, and a high dependency ratio contribute to a high prevalence of poverty in Tajikistan. About 70 percent of the population live in rural areas, and the agricultural sector is by far the largest employer in

the country (61 percent of total employment). Rural and remote areas are significantly poorer than urban settings on average, and face highly volatile incomes compounded by strong seasonality; as a result, the national poverty rate rises by as much as 8 percentage points during the winter and spring months. Public service delivery to most Tajiks is challenged by a mountainous terrain, which accounts for 93 percent of the landlocked country. Progress on poverty reduction and improvements in service delivery and employment are compounded by rapid population growth which, at 2.3 percent as of 2020 is the highest in the ECA region.

3. **Tajikistan is prone to natural disasters such as droughts, earthquakes, landslides, and floods which have health impacts. Climate change is exacerbating natural disaster risks.** Tajikistan's steep mountainous terrain makes it highly susceptible to natural hazards, including earthquakes, floods, landslides, and avalanches. From 1992 to 2016, natural disasters affected 7 million people in Tajikistan – more than 80 percent of the total population – and caused economic losses worth US$1.8 billion.[11] As these events cause disruptions in infrastructure (e.g., in transportation and sanitation systems) and lead to an increase in displaced people that live in temporary shelters, these events increase the risk for disease transmission and outbreaks of various infectious diseases. Moreover, a recent assessment of climate change risk finds that without needed adaptation efforts and disaster risk reduction preparedness and planning, the effects of climate change, and particularly heat and drought, may result in severe loss and damage in Tajikistan.[12] Tajikistan also has the longest border among all countries in Central Asia to Afghanistan, which is currently facing a humanitarian crisis. This creates risk of importing various infectious diseases from the Afghans whose low routine immunization coverage makes them vulnerable to vaccine-preventable diseases, such as polio, measles, pertussis, and diphtheria.[13]

4. **Tajikistan's human capital index (HCI) score of 0.5 reflects the urgent need for investment in human capital development.** Tajikistan has a HCI score of 0.5 in 2020, indicating that a child born today in Tajikistan is expected to be 50 percent as productive as he or she could be if growing up with complete education and in full health.[14] High levels of childhood stunting and poor learning outcomes are the main contributors to Tajikistan's low HCI score which puts the country below the ECA average of 0.62,[15] and regional comparators such as the Kyrgyz Republic (0.60), Kazakhstan (0.63), and Uzbekistan (0.62). Therefore, with lagging health outcomes, there is a substantive loss of human capital, which is a key driver of individual and nationwide prosperity.

Sectoral and Institutional Context

5. **Despite substantive progress in the last two decades, Tajikistan continues to trail other countries in the ECA region in key health indicators, such as life expectancy, child mortality, and stunting. Non-communicable diseases and gender-based violence are on the rise.** Reductions in maternal and child (MCH) mortality are the main drivers of the rapid increase in life expectancy Tajikistan saw in recent decades, from 59 years in 1990 to 71 years in 2019.[16] However, despite these achievements, Tajikistan's health outcomes still lag those of other countries in the ECA region. Large inequities in health outcomes persist – for instance, infant mortality stood at 9 per 1,000 live births in Dushanbe compared to 33 in Khatlon region and was over twice as high in the poorest as in the richest wealth quintile according to estimates from the 2017 Demographic and Health Survey (DHS). While infectious diseases continue to represent a large share of the disease burden, non-communicable conditions (NCDs) such as cardiovascular disease and diabetes are steeply on the rise and now responsible for the majority of death and disability in the country.[17] Another key health challenge is the high and increasing prevalence of gender-based violence (GBV). In the 2017 DHS, despite a suspected high rate of underreporting, 24 percent of ever-married women reported experiencing domestic violence (physical, sexual and emotional) in the year preceding the survey – a 24 percent increase over the previous, 2012, DHS when the rate stood at 19.5 percent.[18]

6. **Lacking access to and poor quality of health services are root causes of Tajikistan's lagging health outcomes.** Formally, all Tajiks are entitled to subsidized health services from public providers, with user fee exemptions for several demographic and socioeconomic groups, including the poor.[19] However, while Tajikistan has achieved high levels utilization of key MCH services like facility delivery and vaccination, access rates are low for NCDs, where only 13 percent of patients with hypertension and 20 percent of those with diabetes were on treatment in a nationally representative survey from 2016.[1] Moreover, stark and growing regional and socio-economic inequities even for services with high national coverage persist, e.g., 98 percent of children are vaccinated against measles in the Sughd region, the rate stands at just 77 percent in Gorno-Badakhshan Autonomous Oblast (GBAO). Gaps in care quality are also pervasive, which means that effective coverage is lower. For example, while almost 90 percent of deliveries took place in health facilities according to the 2017 DHS, immediate breastfeeding and skin-to-skin contact between mother and child were initiated for less than half of births.[2] Moreover, while almost all women access antenatal care, only 68 percent commence it in the first trimester and just 64 percent complete four or more visits (2017 DHS). It is estimated that almost 4,000 deaths per year in Tajikistan could be avoided through better healthcare access and another 5,600 through better health service quality.[3]

7. **Poor primary health care (PHC) quality is also a crucial determinant of high out-of-pocket medical expenditures, and inefficient public health spending. Effective PHC is urgently needed, as rapid population growth adds pressure on a healthcare system already struggling to meet demand.** Improving access to quality care, especially PHC, is not just imperative to improve population health and equity. Lacking quality of PHC facilities leads patients to self-medicate and overuse drugs[23], specialist and inpatient care, causing not just a severe misallocation of scarce public health sector spending but also substantive out-of-pocket (OOP) medical spending risk in the population. In 2019, the OOP share in total health spending stood at 71 percent and 10 percent of the population experienced 'catastrophic' OOP in excess of 10 percent of their household budget. Most OOP spending goes to medicines and medical devices and informal payments to healthcare workers remain common.[24] The need to improve the quality of and stimulate demand for cost-effective PHC services is particularly urgent in light of the rise in NCDs and rapid population growth – 2.1 percent (or 224,000 additional people) as of 2021 compared to a 0.1 percent ECA average – which are continuously increasing demand-side pressures on an already overstretched healthcare supply side.

8. **External funding for health increased during the initial phase of the COVID-19 pandemic, but emergency funding will expire and domestic funding for the health sector is insufficient to finance required investments.** In 2019, the health share in total domestic government spending was 6.9 percent[34] – the lowest share among Central Asian peers and substantively below the 9.8 and 8.8 percent average spending shares across ECA and low- and middle-income countries (LMIC), respectively. In 2019, public healthcare spending from domestic sources amounted to US$18 per capita of which just about US$6.40 (36 percent) went to PHC – far below the US$59 per capita estimated to be required for effective PHC in lower-middle-income countries.[35] The health sector received increase funding from domestic government revenue and development partners (DP) during the COVID-19 pandemic and through this support was able to respond to the most immediate needs.[36] However, public health funding remains fundamentally below levels enabling the provision of quality care to a growing population with

[1] Neelsen, Sven; Egamov, Farrukh; Dorgabekova, Husniya; Mandeville, Kate. 2021. Review of Public Health Expenditure in the Republic of Tajikistan: Discussion Paper. World Bank, Washington, DC. © World Bank. https://openknowledge.worldbank.org/handle/10986/36125 License: CC BY 3.0 IGO.
[2] Ahmed, Tashrik, et al. (2019) "Incentivizing quantity and quality of care: evidence from an impact evaluation of performance-based financing in the health sector in Tajikistan."
[3] The lack of adequate health service access is also reflected in age-adjusted estimates of excess mortality during the Covid19-pandemic where the country had the 55th highest rate out of 191 countries according to estimates by The Economist.

increasingly complex health needs and ensure adequate preparedness and management of future health emergencies.

9. **While progress on healthcare reform has been slow in Tajikistan, the COVID-19 pandemic has created a sense of urgency and momentum among key stakeholders to hasten progress towards universal health coverage (UHC).** Since the second half of 2000s, the Government of Tajikistan has confirmed its commitment to a wide array of health system reforms in various policy documents.[37] However, the development of specific steps to reforms and their implementation has been lagging – in particular, in the field of health financing. The COVID-19 pandemic has demonstrated the consequences of reform inertia and underinvesting in the health sector, both in terms of economic impact and human suffering. At the same time, the success of the national COVID-19 vaccination program has shown the potential of results-focused collective action, spearheaded by the Ministry of Health and Social Protection of Population (MoHSPP), in the health sector. This has galvanized support both from domestic and international stakeholders in Tajikistan, as stipulated in the "Strategy on Healthcare of Population of the Republic of Tajikistan up to 2030" (NHS 2030), to advance on implementation of critical health financing, digitalization, and health service delivery reforms to build a health system that is flexible enough to respond to unexpected challenges. This support is also evidenced by the fact that there is now a renewed interest by the Government of Tajikistan in revising and implementing the Law on Health Insurance, which was adopted in 2008. Thus, there is a window of opportunity to advance on critical reforms needed in the health sector, particularly in health financing.

C. Proposed Development Objective(s)

10. The objectives of the Project are to (i) improve the quality and efficiency of primary healthcare services in selected districts[4] and (ii) strengthen the national capacity to respond to public health emergencies.

Key Results

PDO Elements	PDO Indicators
Quality of PHC services	Number of people residing in the catchment areas of service-ready* district and city health centers
	Number of people residing in the catchment areas of service-ready rural health centers
	Number of outpatient contacts with service-ready PHC facilities
Efficiency of PHC services	Percent of district, city, and rural health centers in pioneer regions contracted
Capacity to respond to health emergencies	**Percent of health alerts generated by routine or immediate reporting that receive initial investigation within 72 hours**

* Service-readiness index scores will be used to distinguish facilities into service-ready and non-service-ready ones. Specific indices are being developed for (i) DHC/CHC and (ii) RHC according to their specific functions.

**Activities under PDO Element 3 are funded by the Health Emergency Preparednes and Response Program (HEPR) Trust Funds, thus the PDO indicator corresponds to the requirements of HEPR M&E Framework.

[4] Improved efficiency of primary healthcare services will be achieved in pioneer areas (Sughd region and Dushanbe City) under Component 2, while improved quality will primarily be achieved in selected districts under Component 1.

D. Project Description

11. **The proposed Project has the following four components that seek to create a healthier nation by improving the quality of PHC services and strengthening national capacity to respond to health emergencies.**

12. **Component 1: Quality Improvements through Primary Healthcare Strengthening:** The objective of this component is to improve the conditions for delivering quality PHC services by making PHC facilities service ready. This will be achieved through investments in service delivery capacity (human resources, infrastructure, and equipment) in the 16 selected districts representing all regions in the country and in interventions to ignite the demand for PHC services among the population. Thus, Component 1 will make facilities service ready and, thereby, improve quality of care where it is most needed. Subcomponent 1.1 will provide funding to build human resource capacity at the PHC level and to stimulate demand for PHC services among the population. Subcomponent 1.2 will finance improvements to physical infrastructure and equipment at the PHC level.

13. **Component 2: Strategic Purchasing of PHC services and Digitalization of PHC Network**: Component 2 supports structural reforms related to strategic purchasing and digitalization of PHC to improve efficiency and quality of PHC services, and to drive enhanced spending efficiency, equity, and financial sustainability of the overall health sector**.** The activities financed under this component are designed to be implemented at national level. Building on lessons learned[5], including from previous pilots in Tajikistan, the Project will be fully integrated in the public finance context and operate by making changes to national systems (e.g., public financial management (PFM) system) rather than relying on Project-specific parallel or temporary arrangements, which may be quicker to implement but less sustainable and effective in the long run. During the project period, the changes to national systems will be developed to allow for digitalization and strategic purchasing at the PHC level and these will be implemented in pioneer regions, Sughd region and Dushanbe city. By paying primary care providers based on a mix of capitation, fee-for-service and other output-based measures this component will introduce a new incentive environment with increased focus on performance and quality of care, that in turn will drive efficiency in health spending.

14. **PBCs are used under Component 2 to strengthen the Project's results orientation and to incentivize structural reforms.** Similar incentives have been used successfully to nudge structural reforms in Tajikistan under the ECDP Project.[6] These PBCs will ensure that the necessary activities to develop policy and institutional changes needed to introduce strategic purchasing and digitalization are not only developed but also approved at the national level, enabling the Project to support their implementation. Furthermore, it is foreseen that additional incentives to nudge changes in the public financial management system important for strategic purchasing and to increase the share of public health expenditures in relation to total public expenditure will be introduced in the forthcoming development policy lending operation.

15. **This component will consist of two sub-components. Subcomponent 2.1 *Strategic Purchasing of PHC services*** will finance a number of national foundational activities needed for a sustainable introduction of strategic purchasing. This includes a national domestic resource mobilization strategy for the health sector, which is essential for the sustainability of Component 2 and to eventually implement the Law on Health Insurance. Moreover, the subcomponent will finance the revision and costing of the national PHC benefit package to

[5] IEG (2014) The World Bank Group Support to Health Financing. An Independent Evaluation. https://ieg.worldbankgroup.org/sites/default/files/Data/reports/chapters/health_finance_evaluation_w_appendix_updated_0.pdf

determine which services the NHF will purchase at the PHC level. At the national level, the subcomponent will finance the development of a service delivery network masterplan to optimize the service delivery network as well as the development and implementation of an accreditation program for PHC providers, as accreditation will eventually be a prerequisite for all providers for contracting with the NHF. In addition, it will finance the development and implementation of a national roadmap for the legal and regulatory changes needed to transition from the current, primarily input-based, PHC payment mechanism to payments based on capitation and outputs. A detailed assessment of needed regulatory and legal changes is currently being conducted to inform this roadmap. This will need to include revision of staffing norms and the deepening of the already initiated changes[7] to the PFM systems to create more autonomy for PHC providers. The subcomponent will also finance the development of a national PHC contracting mechanism, a change management strategy for the structural reforms, and the implementation of strategic purchasing in pioneer areas (Sughd region and Dushanbe city), this includes training of healthcare workers and PHC managers in strategic purchasing.

16. **Subcomponent 2.2** ***Digitalization of PHC network*** will support the digitalization and infrastructure upgrades of the PHC **network.** To provide reliable and quality data for capitation formula and calculation of outcome indicators, this subcomponent will finance development and expansion of the EPR and basic EMR in PHC facilities. The EPR is necessary for implementation of capitation formula, while the EMR system is needed to provide reliable electronic data for calculation of outcome indicators by the NHF. Sub-component 2.2 will finance the implementation of the EPR and EMR in the two pioneer regions (however the EPR and EMR will be developed to allow for national level scale-up), this includes training of healthcare workers and PHC managers in these new systems. Business intelligence (BI) software that will also be developed will collect and processes data from EPR, EMR, and DHIS (already used by MedStat) for analysis and reporting.

17. **Component 3: Health Emergency Preparedness and Response** will strengthen the national HEPR capabilities in Tajikistan to improve the capacity to prevent, prepare, and respond to health emergencies. It will finance the following: (i) technical assistance to conduct detailed assessment of the public health capacities of SES, and to build national capacity to prevent, detect and respond to emergencies, including updating national standard operating procedures (SOP) and protocols, and development of facility-based (PHC) emergency plans in 16 target districts of Component 1; (ii) training of PHC workers in infection prevention and control as well as antimicrobial resistance in 16 project districts and training of epidemiologists at the national level; (iii) providing technical assistance to strengthening the coordination of emergency response between the PHC network and SES; (iv) strengthening laboratory systems of SES regional branches through procurement of transportation of specimen and samples, procurement of basic lab equipment for prevention and detection of disease and minor rehabilitation of lab facilities; (v) training and technical assistance to strengthen community engagement on public health-focused risk communication, including procurement and rolling out of alert systems; (vi) technical assistance for costing of a National Action Plan for Health Security (NAPHS) for introduction of IHR (2005) and implementation of priority activities, including dissemination and advocacy for implementation; (vii) upgrades of regional branches of SES and entry points, including minor rehabilitation, procurement of equipment; (viii) procurement of a limited stockpile of emergency goods as well as items for sanitary quarantine points at the border, as per government-approved lists to be defined in the POM, minor rehabilitation of two warehouses (one ware house of SES at the national level and one warehouse of SES of Khatlon branch) where the stockpile and items for sanitary quarantine points will be kept; (ix) annual simulation exercises of various types and scale to improve functionality of

[7] Through the Disbursement-Linked Indicators in the ECDP, supported by the GFF and the World Bank, the MoF is introducing program-based budgeting (PBB) in district and urban PHC facilities as well as a single program budget line for PHC to allow for more flexibility by PHC managers to move expenditures across expenditures categories, which is needed to implement PBB. To date the regulatory and legal changes needed for these alterations to the public financial management system have been introduced. Yet the implementation of the new changes at the facility level is still work in progress.

emergency coordination mechanism, and (x) technical assistance to increase capacity of the MoHSPP to lead, convene and coordinate assistance related to HEPR. In all activities, participation of women in public health emergency management and decision-making will be enforced by ensuring gender balance among training participants, in working groups/decision-making bodies, in hiring of consultants, policy experts, and by reporting sex-disaggregated monitoring data.

18. **Component 4: Project Management, Coordination, and Results Monitoring** will finance project management and operating costs as well as project audits. To strengthen policy dialogue, coordination of the sector and capacity to implement structural reforms, the component will finance institutional strengthening of MOHSPP and MOF. It will also provide technical assistance and training for the establishment of a Health Policy and Analysis Unit (HPAU) in the MOHSPP for the first 3 years of the Project and in the area of health financing primarily targeting the social expenditure department in the MoF. In addition, it will support procurement of equipment and furniture for the new MoHSPP building, which will house all key MoHSPP-subordinated organizations and sectoral investment projects, to allow for improved stewardship of the MoHSPP and better coordination of DP assistance in the sector. **This component will also support nationally and sub-nationally representative health facility surveys to facilitate project monitoring and evaluation (M&E).** The component will finance 8 biannual FASTR surveys staring in 2024 until the end of the Project period, which collect data on service-readiness, as well as one endline SDI survey in 2027, that gathers information on wide range of structural and process quality indicators.

19. **Component 5: Contingent Emergency Response.** The objective of this component is to improve Tajikistan's capacity to respond to disasters. Following an eligible crisis or emergency, the Recipient may request the Bank to reallocate project funds to support emergency response and reconstruction. This component would draw from the uncommitted grant resources under the Project from other project components to cover emergency response. An emergency eligible for financing is an event that has caused or is likely imminently to cause, a major adverse economic and/or social impact to the Recipient, associated with a disaster. The POM will include a specific annex for the Contingent Emergency Response Component, which lays out the provisions for activating and implementing the component.

Legal Operational Policies

	Triggered?
Projects on International Waterways OP 7.50	No
Projects in Disputed Areas OP 7.60	No

Summary of Assessment of Environmental and Social Risks and Impacts

20. Both the Environmental and Social Risks are rated Moderate. The project Component 1.2 will finance to build limited priority primary healthcare centers (PHCs) and warehouses in 16 districts, as well as to renovate, equip, and modernize existing PHCs. Additionally, the client has prior knowledge of implementing the World Bank Environmental and Social Framework (ESF). Due to the small number of civil construction, improvement, and rehabilitation projects, the overall environmental risks will be low to moderate. The installation or repair of incinerators, the construction of warehouses, the expansion of current medical facilities, and the acquisition of equipment are examples of infrastructure modernization activities that will not have a significant negative impact on biodiversity or natural habitats. The following are some of the potential environmental impacts and risks

associated with the construction of PHCs: (i) an increase in healthcare waste due to poor waste management in terms of waste color coding, segregation, collection, decontamination, transportation, and disposal; (ii) risks to the occupational health and safety of healthcare workers; (iii) risks to the community's health and safety associated with the operation of healthcare facilities; and (iv) air pollution. These risks should be site-specific, reversible, and managed by means of established and effective mitigation techniques. These will be mitigated by: (i) enhancing the ability of health facilities to meet ESF requirements, particularly Environmental and Social Standards (ESS) 2 and 3: Resource Efficiency and Pollution Prevention and Management; (ii) implementing environmental safeguards' tools developed for the project; and (iii) adhering to international best practices during the construction and operational phases. An Environmental and Social Management Framework (ESMF) is prepared during the project appraisal stage. The ESMF establishes procedures for screening sub-projects, mitigation measures, and implementation arrangements. It provides necessary provisions for storing, transporting, and disposing of medical waste. A template for the ICWMP (infection control and waste management plan) is also included in the ESMF. The ICWMP, which complies with international best practices and World Health Organization standards, shall be created in the early stages of project implementation.

21. The project will have social positive impacts, as it will contribute to (i) improving the quality and equity of PHC services in selected districts/regions and (ii) strengthening the national capacity to respond to health emergencies. Social risks could emanate from the following planned investments: (i) investments in PHC service delivery capacity (human resources, infrastructure, and equipment) in at the PHC in selected districts and at the national level, and (ii) national capacity and physical infrastructure enhancement to improve response to various emergencies, including training of health workers; repairs, rehabilitation, expansion, equipping, and modernization of public health workplaces; construction of a few new PHCs and warehouses for emergency medical equipment and goods at the regional level; and procurement of medical goods to stockpile for future emergencies. One of the key challenges for the project will be to ensure social 'inclusion'. Exclusion may happen due to differentials in (i) geography - given the vast expanse of the PHC facilities throughout the country and the fact that some of the terrains are mountainous and remote, so some remote districts and villages will be excluded; (ii) scale of investments - large and richer districts/regions may receive preferential investments; (iii) absorption capacity - technologies developed should be more friendly to health workers at large, and (iv) administrative expediency and economy in reaching out to rural health workers and vulnerable households in remote and poor areas across the country. These risks will be addressed to a large extent through a well-crafted Stakeholder Engagement Plan (SEP) supplemented with an effective Information, Education, and Communication campaign. Subcomponents 1.2, 2.2, and 3 involve civil construction, some new and others only repair, extension, and rehabilitation. The new construction will invariably require land acquisition. While the project is expecting that the Government will make land available, due diligence is required to ensure that there is no resultant physical, and/or economic displacement. Risks related to this will need to be avoided or reduced or, if the involuntary acquisition is inevitable, then, it will have to be addressed. The project has prepared, consulted upon, and disclosed a Resettlement Framework (RF). It will guide the preparation of site-specific resettlement plans, where required. Another challenge will be sensitizing the implementing agency and other relevant stakeholders to adopt and adhere to the ESF requirements, as some regional and local stakeholders will be new to ESF requirements. There are also risks related to institutional capacity, in particular concerning the transparency of decisions made on subproject prioritization and accountability on project investments. The proposed Third-Party Monitoring to be implemented by civil society organizations (CSO) is expected to recommend areas for improvement and course correction to MoHSPP and its relevant subdivisions to complement and strengthen their existing planning, monitoring, and evaluation processes, as well as to seek ESF compliance. Labor-related risks associated with the civil works contractors and their compliance with ESS 2 are assessed as Moderate, as the national labor and occupational health and safety (OHS) legislation is in place and the contractors must comply with them. The risk of child and forced labor is not expected.

22. Similarly, the project is assigned a moderate risk rating for Sexual Exploitation and Abuse/Sexual Harassment (SEA/SH). The capacity of health workers in identifying and registering GBV cases needs to be strengthened. The existing referral and coordination services in the health facilities are malfunctioning, as the system does not provide comprehensive care to survivors. In response, the project will support the development of a national policy to guide the health sector GBV response. It will also finance the implementation of selected activities to recognize, prevent and respond to GBV at the PHC level.

E. Implementation

Institutional and Implementation Arrangements

23. Given the reform orientation and complexity of the Project, institutional and implementation arrangements will be tailored to ensure smooth implementation and successful achievement of the PDO.

24. **The MoHSPP will be the Project implementing agency, with day-to-day project coordination responsibility entrusted with the Directorate for Reforms, Primary Healthcare, and International Relations (DRPHCIR).** DRPHCIR will report, through its Head, to the First Deputy Minister of Health and Social Protection of Population/Project Coordinator, and the latter, in turn, will report to the Minister of Health and Social Protection of Population/Project Director. Final accountability for project implementation will rest with the Minister and the First Deputy Minister.

25. **MoHSPP intra-sectoral project oversight, similar to HSIP, will be provided by the MoHSPP *Project Coordination Group (PCG)*.** This Group will be chaired by the First Deputy Minister of Health and Social Protection of Population in his capacity of ***Project Coordinator*** and consist of heads of all relevant MoHSPP technical and supporting departments, with DRPHCIR acting as the ***PCG Secretariat***. Each technical department will be responsible for leading technically one project component/subcomponent, as follows: C1.1: Directorate for Medical and Pharmaceutical Education, Human Resources for Health Policy and Science; C1.2: Capital Construction Directorate; C2. Directorate of Economics and Budget Planning for Health and Social Protection and HPAU (digital); C3. Directorate for Sanitary and Epidemiological Safety, Emergency and Emergency Care and HPAU (health emergency); and C4. Directorate for Reforms, Primary Healthcare, and International Relations (or International Relations Unit within this Directorate). The PCG members will provide oversight, technical guidance, and policy direction to their respective component/subcomponent, with the First Deputy Minister overseeing implementation of Components 1, 2, and 4, and Deputy Minister responsible for Sanitary and Epidemiological Surveillance/Chief Sanitary Doctor overseeing Component 3. Similar to HSIP, implementation will be executed by a ***Technical Support Group (TSG)***, including its regional offices, consisting of local project implementation support personnel in adequate number and with adequate qualifications, with all of them reporting to the First Deputy Minister of Health and Social Protection of Population and working in close day-to-day coordination with DRPHCIR.

26. **Inter-sectoral project oversight, primarily for reform-oriented Component 2 and other activities requiring inter-sectoral collaboration, will be provided through an *Inter-Sectoral Committee (IC)*.** It will be set up under the Government of Tajikistan, chaired by the First Deputy Prime Minister, with the Minister of Health and Social Protection of Population and the Minister of Finance as co-chairs, and consisting of relevant officials, at least at the deputy minister level or higher from the Ministry of Justice, Ministry of Finance, Ministry of Economic Development and Trade, Tax Committee, Anti-Monopoly Agency, Agency for State Financial Control and Combatting Corruption, Committee on Local Government, Ministry of Industry and New Technologies (Digital), State Committee on Investments and Management

of State Property, Sughd Oblast Local Government, Dushanbe City Local Government at a level of senior management. The IC will also include relevant development partners, who work on matters related to Component 2, as specified in the Terms of Reference of the IC. DRPHCIR will act as the IC Secretariat. The IC will have the mandate to coordinate and review national health financing policy, including consider and decide on matters of inter-sectoral nature related to Component 2 and requiring concerted efforts from several government agencies involved. The IC will meet bi-annually or when called by the IC Chair or the Deputy Chair.

27. **Oversight of fiduciary functions, including procurement, financial management, auditing, and reporting, will be the ultimate responsibility of MoHSPP**, with specific expertise and support in these areas to be provided by the TSG. Financial management (FM) will be carried out by one full-time FM head specialist in the TSG, as well as two disbursement specialists in close coordination with the MoHSPP Directorate for Economics and Budget Planning for Health and Social Protection. Procurement will be implemented by one procurement head specialist and one procurement specialist having experience in international procurement and good command of written and spoken English. Compliance with World Bank environmental and social policies will be the responsibility of the MoHSPP, with support from one social development specialist and one environmental specialist in the TSG. All reporting and oversight relationships will be summarized in the POM.

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