



Project Information Document (PID)

Concept Stage | Date Prepared/Updated: 21-Jul-2022 | Report No: PIDC34321

**BASIC INFORMATION****A. Basic Project Data**

Country Tajikistan	Project ID P178831	Parent Project ID (if any)	Project Name Millati Solim: Tajikistan Healthy Nation Project (P178831)
Region EUROPE AND CENTRAL ASIA	Estimated Appraisal Date Oct 10, 2022	Estimated Board Date Feb 02, 2023	Practice Area (Lead) Health, Nutrition & Population
Financing Instrument Investment Project Financing	Borrower(s) Republic of Tajikistan	Implementing Agency Ministry of Health	

Proposed Development Objective(s)

The Project Development Objective (PDO) is to improve the quality and equity of primary healthcare services and strengthen the national capacity to respond to health emergencies.

PROJECT FINANCING DATA (US\$, Millions)**SUMMARY**

Total Project Cost	67.25
Total Financing	67.25
of which IBRD/IDA	50.00
Financing Gap	0.00

DETAILS**World Bank Group Financing**

International Development Association (IDA)	50.00
IDA Grant	50.00

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

Concept Review Decision

Track II-The review did authorize the preparation to continue

Other Decision (as needed)

B. Introduction and Context

Country Context

1. **Tajikistan is a lower-middle-income IDA country in Central Asia with a large proportion of the population vulnerable to poverty and external economic shocks.** The country is land-locked with a population of 9.8 million¹. Between 2009 and 2019, GDP per capita grew by a robust average rate of 4.7 percent per year. The country was also one of the few to register GDP per capita growth in 2020, at 2.1 percent, and in 2021, growth estimates accelerated to 6.8 percent. Nevertheless, as of 2020, GDP per capita remained the lowest in the World Bank's Europe and Central Asia (ECA) region², at US\$891.³ Moreover, 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 (29 percent of GDP in 2019), which primarily derive from Russia. Due to the slowdown of the Russian economy, first due to COVID-19 and now because of the sanctions imposed in response to Russia's invasion of Ukraine, the Tajik economy is expected to shrink by about 2 percent in 2022.⁴ The adverse macroeconomic environment, with inflation and high food prices, is also expected to impact food and nutrition security as Tajikistan remains highly dependent on import to cover its food needs and avail agriculture input.⁵ By the end of 2022, the number of food insecure people will reach 2.9 million, constituting 30 percent of the country's population - an increase from nearly 20 percent (1.9 million of the population) in 2021.⁶

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 population living below the national poverty line decreased from more than 34 percent in 2013 to about 26 percent in 2019 when the poverty line stood at 213 Tajik Somoni (TJS), or US\$21, per person per month.⁷ An estimated 15 percent of the

¹ Where not otherwise indicated, data and qualitative information in this and the following paragraphs in this section come from either [Neelsen et al. 2021. Review of Public Health Expenditure in the Republic of Tajikistan: Discussion Paper. World Bank, Washington, DC](#) or the [Tajikistan section of the World Bank Macro Poverty Outlook Europe and Central Asia – Spring Meetings 2022](#).

² The World Bank ECA region comprises the following countries: Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Bulgaria, Croatia, Georgia, Kazakhstan, Kosovo, Kyrgyz Republic, Moldova, Montenegro, North Macedonia, Poland, Romania, Russian Federation, Serbia, Tajikistan, Turkey, Turkmenistan, Ukraine, and Uzbekistan.

³ [With a 2020 GNI per capita of US\\$1,060, Tajikistan lay just above the lower-middle-income country threshold of US\\$1,045.](#)

⁴ [World Bank, Tajikistan Macro-Poverty Outlook, Spring 2022, June update](#)

⁵ [World Bank, Tajikistan Macro-Poverty Outlook, Spring 2022, June update](#)

⁶ WFP (April 2022). Food Security Update and implications of Ukraine Conflict in Tajikistan. Retrieved from <https://docs.wfp.org/api/documents/WFP-0000139165/download/>

⁷ [World Bank Poverty and Equity Brief Europe and Central Asia – Tajikistan – April 2022.](#)



population found themselves below the international poverty line of US\$3.20 (2011 PPP). Underemployment and informality (half of the labor force is informal⁸), 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 infectious disease outbreaks and natural disasters such as droughts, earthquakes, landslides, and floods which have severe health impacts. Climate change is exacerbating natural disaster risks. Tajikistan’s steep mountainous terrain make it highly susceptible to many natural hazards, including earthquakes, floods, landslides, and avalanches. This often leads to outbreaks of various infectious diseases and injuries. 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.⁹ A recent assessment of climate change risk moreover 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.¹⁰ 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 Afghans whose low routine immunization coverage makes them vulnerable to vaccine-preventable diseases, such as polio, measles, pertussis, and diphtheria.¹¹

4. Tajikistan’s human capital index (HCI) score of 0.5 reflects the urgent need for investment in human capital development. Tajikistan has a human capital index (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.¹² 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 0.62,¹³ 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.

5. Health sector investments are an effective and efficient way for Tajikistan to improve health and human capital, foster economic growth shared prosperity and improve disaster preparedness. A large body of evidence now documents that health sector investments yield the highest returns when they are targeted towards the most vulnerable, focus on public health interventions (prevention) and primary healthcare, and promote good health from the earliest life stages.¹⁴ The COVID-19 pandemic moreover highlights that building health systems with robust response capacity to disasters and disease outbreaks averts large future economic and health costs. Allocative efficiency – spending on the right things – is only one condition for the various benefits of health sector investments to fully materialize. Equally important is technical efficiency – that health sector resources are spent in the right way and are used to narrow health equity gaps in the country. It is therefore important that efforts be made to maximize the human development yields of Tajikistan’s healthcare spending

⁸ World Bank, Tajikistan: Policy Note on Informality. Declining Informality Amidst Weak Employment Growth. Macroeconomics, Trade and Investment Global Practice, Europe and Central Asia Region, 2020.

⁹ <https://www.gfdr.org/sites/default/files/publication/Tajikistan.pdf>

¹⁰ [Climate Risk Country Profile: Tajikistan, 2021. The World Bank Group and the Asian Development Bank.](#)

¹¹ World Bank: Tajikistan Multi-Sector Refugee Needs and Impact Assessment, Europe and Central Asia Region, 2022.

¹² For a methodological overview of the HCI see [Kraay, 2019. The World Bank Human Capital Index : A Guide. Published by Oxford University Press on behalf of the World Bank.](#) The HCI defines complete education as 14 years of high-quality schooling by age 18 and full health as no stunting and 100 percent adult survival.

¹³ Unweighted average across ECA countries except Turkmenistan for which no data is available.

¹⁴ For a comprehensive description of the economic benefits of health sector investments see [Tandon et al. 2021. Making the Case for Health: A Messaging Guide for Domestic Resource Mobilization. Joint Learning Network for Universal Health Coverage.](#)



through both allocative and technical efficiency enhancements and improve health equity.

Sectoral and Institutional Context

6. 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, while also seeing an increasing burden of noncommunicable diseases. Mortality reductions among mothers and children are the main cause of a rapid increase in life expectancy in recent decades—from 59 years in 1990 to 71 years in 2019 — this is in step with overall trends in low- and lower-middle-income countries¹⁵. Despite this improvement, Tajikistan’s health outcomes still lag those of other countries in the ECA region (Table 1) as many of the health outcome shortfalls are amenable to improved health services. 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.¹⁶ Tajikistan finds itself in the middle of an epidemiological transition where it faces challenges of a large burden from infectious diseases and Maternal and Child Health (MCH) conditions (particularly under-five and neonatal mortality) with a simultaneous rise in the prevalence of noncommunicable disease (NCDs), which are often chronic conditions typical of richer and aging societies. Among the NCDs, cardiovascular conditions and diabetes are steeply on the rise and now form the largest cause of death and disability in the country.¹⁷ For instance, diabetes diagnoses have increased over 90 percent over the past decade.¹⁸ NCD prevention and management relies heavily on a functional primary health care system, therefore the strong upward trend in NCD burden underscores the urgency of expanding high-quality primary care services in Tajikistan.

7. Tajikistan has achieved a high level of MCH care coverage. However, despite the overall high coverage rate in MCH care, stark regional and socioeconomic inequities persist. Access to skilled delivery care (94% in 2017) and full childhood vaccination rates (83% in 2017) are high especially compared to countries of similar income levels. Still inequities in healthcare access continues to pose a challenge – for example, while 99 percent of women deliver in health facilities and 98 percent of children are vaccinated against measles in Sughd, the rates stand at 76 and 77 percent in GBAO, respectively.

8. While Government health expenditure per capita has grown in the past decade, it falls short of providing a basic benefit package to a large part of the population. The Tajik health care system is characterized by central planning, a decentralized administrative structure, and insufficient input-based financing. Almost all health care services are provided by the public sector. As of 2019, public healthcare spending in Tajikistan amounted to US\$18 per capita – far below the spending levels in other countries in the region (Table 2). This is insufficient to allow for the provision of a basic benefit package for at least 80 percent of the population, which is estimated at US\$40–79 per capita.¹⁹ Almost all public healthcare funding comes from the government general revenue as the external financing share is low and there is no contributory social insurance. This has resulted in a significant proportion of overall health expenditure being directly funded by households through out-of-pocket payments (see section below). There is low government spending in the health sector. In

¹⁵ 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.

¹⁶ 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](#).

¹⁷ Vos et al. 2020. Global burden of 369 diseases and injuries in 204 countries and territories, 1990–2019: a systematic analysis for the Global Burden of Disease Study 2019. *The Lancet* 396 (10258):1204-1222.

¹⁸ Vos, T, SS Lim, C Abbafati, KM Abbas, M Abbasi, M Abbasifard, M Abbasi-Kangevari, H Abbastabar, et al. 2020. "Global burden of 369 diseases and injuries in 204 countries and territories, 1990–2019: a systematic analysis for the Global Burden of Disease Study 2019." *The Lancet* 396 (10258):1204-1222. doi: 10.1016/S0140-6736(20)30925-9.

¹⁹ Watkins et al. 2020. Resource requirements for essential universal health coverage: a modelling study based on findings from Disease Control Priorities. *The Lancet Global Health* 8 (6): e829-e839.



2019, the most recent year for which internationally comparable data are available, the health share in total government spending was 6.9 percent – 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) countries, respectively. The COVID-19 pandemic triggered a substantive increase in both domestic and external health spending which raised the 2020 share to 10.4 percent. Since then, however, it has again been on a downward trend, dropping to 9.7 percent in 2021 with a projected decrease to 8.6 percent in 2022.²⁰

9. **PHC service delivery is characterized by low quality of care, duplication, and poor integration with the higher levels of care.** During the Tajik civil war in 1992-1997, the health system mostly disintegrated, and the subsequent peace treaty targeted the establishment of a system based on strong PHC, with a focus on family medicine practice. Currently, general PHC services are provided under a locally funded and administered district or city health centers, as well as rural health centers and health houses. In 2017, about 70 percent of the PHC network applied family medicine principles. Still a large part of PHC functions (reproductive health, integrated management of childhood disease, immunization, or tropical diseases, sexually transmitted diseases, tuberculosis) are provided by centrally government funded and administered specialized centers (vertical programs). This lack of integration of vertical programs leads to duplication and low productivity and undermines the continuity and coordination of care. One of the goals of the 2010-2020 National Health Strategy was to integrate PHC services delivered by various specialized care centers into PHC facilities. However, implementation has been limited.

10. **Moreover, the basic conditions for providing quality PHC services are not present in the PHC network, which suffers from poor infrastructure, lack of equipment, and poor providers' capacity to deliver quality of care.** Data on quality of care is very limited, but existing evidence show that it is poor, both in terms of providers knowledge and physical inputs, and that it varies strongly across regions. For example, a 2015 survey of PHC facilities found that (a) only small shares of family doctors and nurses successfully passed a basic knowledge test for the diagnosis of cardiovascular conditions; (b) only two out of nine essential drugs were available in more than 50 percent of facilities; and that (c) only around half of health houses, which form the first line providers for the majority of the population, had access to clean water, a functional toilet, and heating. The same survey found substantive regional inequities in service readiness: In the poorer Khatlon oblast, with a population of 3.3 million, 20 percent of rural health centers had no functional toilet and only half access to clean water, while the corresponding rates amounted to 8 and 83 percent in Sughd, respectively. Supply-side readiness to deliver quality health services must improve particularly in the least served areas of the country as this is a critical step to lay the foundations for strategic purchasing in the country.

11. **Besides lacking provider knowledge and performance, human resources for health are plagued by an inadequate skill mix.** Like other former Soviet countries, Tajikistan employs an unusually large number of healthcare workers per population – 7.3 per 1,000 inhabitants compared to the average 5.7 (2.6) per 1,000 inhabitants across all upper (lower) middle-income countries. Yet, most of these healthcare workers are low-skilled nurses that are not allowed to carry out many basic tasks. The share of general practitioners and family medicine doctors among all physicians remains low, particularly in rural areas, despite efforts in recent years to train and place more family doctors and strengthen their role as gatekeepers for higher level of care. This is partly due to brain drain of qualified health professionals seeking better work conditions and higher pay in the Russian Federation and other countries.²¹ The limited available data indicate low health worker productivity. For instance, a 2016 study of PHC facilities in Sughd and Khatlon shows that clinical staff see a mere 3.8 patients per day on average.²²

²⁰ Budget and expenditure data from Ministry of Finance of the Republic of Tajikistan.

²¹ WHO. 2020. Health-related SDG targets in Tajikistan: implementation of policies and measures for health and well-being. Progress Report.

²² 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."



12. **The COVID-19 pandemic showed that Tajikistan requires substantive investments to enable adequate prevention and management of health emergencies.** The pandemic exposed gaps in equipment and health worker knowledge. This lack of emergency response capacity is reflected in Tajikistan’s positioning in international health security rankings. With an overall self-assessed capacity of 62 percent (2019) in the World Health Organization (WHO) International Health Regulation Capacity Progress report, the country’s ability to prevent, detect and respond to infectious diseases is below the regional and global averages of 74 percent and 64 percent, respectively, with food safety and laboratory capacity as the greatest challenges.²³ In the 2021 Global Health Security Index, Tajikistan ranks 140th out of 195 countries with an index score of 29 out of 100 (overall global average 39) with particular vulnerabilities identified in terms of emergency governance, laboratory and general capacity in clinics, hospitals, and community care centers.²⁴ These assessments show that Tajikistan has critical gaps in the national Health Emergency Preparedness and Response (HEPR) program capabilities and is currently struggling to finance and build resilient HEPR systems.

13. **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.²⁵ However, the development of specific steps to reforms and their implementation has been lagging – in particular in the field of health financing where apart from the limited per capita financing policy outlined above and a number of regional pilot projects which have introduced performance-based financing (World Bank) and case-based payments for hospitals (Asian Development Bank) these initiatives have not been scaled-up nationwide. 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 provided evidence that it is possible to get things done in the health sector. This has galvanized support both from domestic and international stakeholders in Tajikistan to advance on the implementation of critical health financing and health service delivery reforms to build a health system that is flexible enough to respond to unexpected challenges. This is, for instance, evidenced by the fact that there is now a renewed interest by the Government of the Republic of Tajikistan to revise and implement the Law on Mandatory Health Insurance (MHI), which was adopted in 2008. Thus, there is a window of opportunity to advance on critical reforms needed in the health sector.

Relationship to CPF

14. **The Project is aligned with the FY19-23 World Bank Country Partnership Framework (CPF) and seeks to address the binding constraints identified in the Systematic Country Diagnostics (SCD).** The Project contributes to achieve the objectives of Pillar 1 (Human Capital and Resilience) of improving nutrition, hygiene, and reducing the under-five mortality rate, which is still high. It directly contributes to the second objective of the CPF, Enhancing Health Services, and the CPF’s indicators under this objective are: (i) number of children under thirteen months of age who received all doses of all vaccines according to the national immunization schedule of the ongoing Health Services Improvement Project (HSIP)

²³ Tajikistan scores 20% in three areas (C.1.2 [gender equality on health emergencies], C.7.1. [health emergency management] and C.9.1. [infection prevention and control]). Other weaknesses identified in the SPAR were laboratory, financing, IPC capacity across the system, Risk Communication and Community Engagement (RCCE), IHR Coordination, food safety, etc. See <https://extranet.who.int/e-spar/Home/CapacityScoreDetails> for more information.

²⁴ https://www.ghsindex.org/wp-content/uploads/2021/12/2021_GHSindexFullReport_Final.pdf

²⁵ See, for instance:

- [Ministry of Health of the Republic of Tajikistan. 2010. National Health Strategy of the Republic of Tajikistan 2010-2020. Dushanbe.](#)
- [Government of the Republic of Tajikistan. 2016. National Development Strategy of the Republic of Tajikistan for the period up to 2030. Dushanbe.](#)
- Government of the Republic of Tajikistan. 2019. Decree of the Government of the Republic of Tajikistan from 6 August 2019, №394. Strategic Plan on Health Financing Reform in the Republic of Tajikistan for the period 2019-2021. Dushanbe.



districts; (ii) percentage of children aged 0-24 months, whose weight and height are measured according to the recommended schedule, and whose parents' received advice on proper nutrition and childcare in HSIP districts; and (iii) percentage of population vaccinated against COVID-19 through the Tajikistan Emergency COVID-19 Project (TEC-19).

15. **The Project will contribute to the government's overall strategic objective of human capital development, stated in the "National Development Strategy of the Republic of Tajikistan for the period of 2030" (NDS 2030).** The proposed project would contribute to and support the overall goal of the recently adopted "Strategy on Healthcare of Population of the Republic of Tajikistan up to 2030" (NHS 2030) to provide every citizen of Tajikistan with accessible and quality healthcare through effective governance, sustainable financing, workforce provision and development of information technologies. As explained below, the proposed project would fund activities specified in the Prioritized Investment Plan (PIP) that operationalize the NHS 2030. As mentioned above, there is a renewed interest by the Government of the Republic of Tajikistan to revise and implement the 2008 Law on MHI. The proposed project activities would correspond to the recommendations of the World Bank's recent review of the MHI law²⁶ as well as the needs identified by a high-level working group that are advancing the revisions of the MHI Law and its implementation. Additionally, the proposed project activities are well-aligned with other national and sector-specific strategic documents and action plans.

16. **Proposed investments are in line with the 2030 Agenda of the Sustainable Development Goals (Goal 3) on health and well-being,** in particular SGD 3b (providing access for affordable essential medicines and vaccines), SDG 3c (substantially increase health financing and the recruitment, development, training, and retention of the health workers) and SDG 3d (strengthen the capacity for early warning, risk reduction and management of national and global health risks). Additionally, the key elements of the proposed project fulfills the commitments made in "*the Joint Statement in Support of Strengthening Primary Health Care in the Republic of Tajikistan*" signed by the Ministry of Health and Social Protection and development partners in May 2022, which outlines a common vision for reimagining PHC by building stronger governance mechanisms, prioritizing financing and resourcing for PHC, addressing critical shortages of qualified health workers, investing in infrastructure development and renewal, and expanding the scope of work of PHC to tackle a wider range of health conditions. It also supports the commitment made by the World Bank, the Global Financing Facility (GFF) and other development partners by co-signing "*the Joint Statement in Support of Health Financing Transition in the Republic of Tajikistan*" to support strategic health financing transitions in Tajikistan, signed in the fall of 2021.

17. **The proposed project seeks to scale-up successful efforts to improve the quality and equity of primary healthcare services currently implemented at a smaller scale with support from the World Bank and other development partners.** Since 2013 the World Bank has financed the Health Services Improvement Project (HSIP) (US\$45 million), which aims at improving access and quality of basic PHC in 16 districts, where approximately 2.2 million people (22 percent of the population) reside. HSIP closes June 30, 2023. The proposed operation builds on the lessons learned from the Ministry of Health and Social Protection's (MoHSP) implementation of HSIP and seeks to scale-up some of the most successful activities financed by HSIP, including the training of healthcare workers to improve the quality of care at the PHC level, usage of mobile-engage and citizen scorecards to stimulate demand for PHC services, etc.²⁷ The proposed project also builds on investments from other developing partners, including e.g. the WHO PHC strategic purchasing pilot in five districts in Sughd region and the work by German Agency for International Cooperation (GIZ) on accreditation of PHC facilities, both efforts financed by the European Union (EU). Through the Prioritized Investment Plan (PIP) process, described below, the World Bank is working closely with the Government and development partners to ensure that the proposed operation scales-up the most promising smaller scale activities/programs at the national level and codifies them in national legislation and regulation.

²⁶Zine Eddinne El Idriss and Sjoblom (2022), Tajikistan: Policy Note on Mandatory Health Insurance, Europe and Central Asia Region, World Bank.

²⁷ The Performance-Based Financing Program, supported by HSIP, will not be continued as it is not financially viable for the government to scale-up.



C. Proposed Development Objective(s)

The PDO is to improve the quality and equity of primary healthcare services and strengthen the national capacity to respond to health emergencies.

Key Results (From PCN)

Proposed PDO indicators are:

PDO Elements	PDO Indicators
Quality	Percentage of population with access to service ready PHC facilities*
Equity	Real public expenditure for primary health care (PHC) increases The Gini coefficient of district per capita PHC budgets decreases
Capacity to respond to health emergencies	Increase in number of laboratories upgraded to enhance capacity to address epidemic outbreaks/ public health emergencies (PREP6) SPAR indicator related to human resource capacity (PREP3) increase by one point

Notes: In the absence of readily available data on (equity in) health outcomes, the project PDOs use indicators of service readiness and healthcare funding as proxies.

* Service readiness will be measured through rapid-cycle phone surveys to a sample of health facilities (pioneered and financed by the GFF), access is defined by people living in the catchment areas of a service ready PHC facility.

** In the absence of regularly available household survey data to monitor socioeconomic and regional inequities in access to and quality of healthcare services, our Equity PDOs are: (1) An increase in absolute spending on PHC since PHC spending – as opposed to spending on higher levels of care – has been shown to be strongly pro-poor; and (2) A reduction in the Gini coefficient of per capita PHC funding across districts as a measure of regional inequity in the distribution of PHC funding. Because the facility improvements under Component 1 will prioritize districts which are hard-to reach, poor, and/or have low PHC outcomes, the Quality PDO also has a strong equity dimension.

*** PDO Indicator related to capacity to respond to health emergencies is sourced from the Monitoring and Evaluation Guidance Note from the Health Emergency Preparedness and Response (HEPR) Umbrella Program, as per the Trust Fund’s requirements.

D. Concept Description

The proposed Project seeks to improve the quality and equity of PHC services and strengthen national capacity to respond to health emergencies.

Component 1- Primary Healthcare Strengthening (US\$39 million [US\$ 32 million from IDA and US\$7 million from GFF])

18. **The objective of this component is to invest in PHC service delivery capacity (human resources, infrastructure, and equipment) to create the conditions for accreditation of PHC providers in selected districts.** The component also scales-up activities to stimulate demand for PHC services among the population. The component will increase equitable access to PHC services and improve quality of care. Initial criteria for district selection include districts that: (i) are hard-to reach; (ii) are poor; (iii) have low PHC outcomes; and (iv) are/have not been covered by other investment projects (Health Service Improvement Project and or Early Childhood Development Project) or by other development partners (e.g., GIZ/European Union investment program in PHC, JICA’s new PHC Program).²⁸ The investments under

²⁸ Given the selection criteria it is likely that border districts, especially in Khatlon, a region with poor health indicators and with exposure to receiving



Component 1 will also serve to incentivize local stakeholders to implement some of the reforms under Component 2, such as pooling of district level budgets at higher levels.²⁹ Component 1 will support: - Component 1.1. Quality Improvements through investments in human resources and demand stimulation and Component 1.2: Physical infrastructure improvements:

Component 2 -Strategic Purchasing of PHC Services (US\$20 million [US\$15 million from GFF and US\$5 million from IDA])

19. The objective of this component is to start implementation of strategic purchasing of primary healthcare services. The component will build the foundations for introducing strategic purchasing in the health sector, first in primary care, starting with the Sughd Oblast as a front-runner region. This includes the creation of a single-payer purchaser with regional branches and building of core strategic purchasing functions, including specification of the benefits package, contract arrangements, provider payment, and performance monitoring.³⁰ As mentioned, this component complements and builds on ongoing work by other partners, e.g. WHO/EU (on strategic purchasing of primary care particularly in Sughd region), GIZ (on accreditation of service provider) and the performance-based financing program financed by the World Bank, through HSIP. Selected activities under this component will be incentivized with *Performance-Based Conditions* (PBCs), that will be developed during project preparation.

Component 3 -Health Emergency Preparedness and Response (US\$4.75 million from the HEPR Trust Fund)

20. The objective of this component is to strengthen the Health Emergency Preparedness and Response system in Tajikistan to improve the capacity to prepare, prevent, and respond to health emergencies. The Sanitary and Epidemiological Services (SES) under the MoHSP is responsible for all health emergencies that may arise. The SES has public health facilities that are not part of the PHC network, although its system relies on PHC network for many critical functions in times of emergencies.

Component 4 – Project management, coordination, and monitoring and evaluation (US\$3.5 million [US\$3 million from IDA and US\$0.5 million from GFF])

21. This component will provide support for the execution of project management, coordination, and monitoring and evaluation (M&E) activities, including third party monitoring. Support will also be provided to the existing International Cooperation Unit to strengthen its capacity to provide effective coordination of external relations and projects. The component will finance consulting services, including consultants to staff the PIU, liaison officers for coordination with the MoF, MoHSP and local government authorities of the targeted districts. In addition, the component will finance office equipment, training, audits, filing systems and operating costs.

Afghan refugees, will be included for investments. The task team is working with an Inclusion and Resilience Lens (IRL) in this operation and is brainstorming with IRL experts to ensure that the project will contribute to inclusion of vulnerable groups and build resilience in Tajikistan.

²⁹ The implementation of strategic purchasing will imply that e.g., district level health budgets will be reduced as pooling of resources will occur at the national level. This can raise concerns among district level officials. Investments envisioned under Component 1 can be used to create more supporters for the reform activities proposed under Component 2.

³⁰ The strategic health purchasing progress tracking framework was used to design this component. For more information see, Cashin C, Gatome-Munyua A. The strategic health purchasing progress tracking framework: a practical approach to describing, assessing, and improving strategic purchasing for universal Health coverage. *Health Syst Reform*. 2022;8(2): e2051794. doi:<https://doi.org/10.1080/23288604.2022.2051794>.



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

Summary of Screening of Environmental and Social Risks and Impacts

22. The project's Environmental Risk is Moderate at this stage. Under Components 1 and 3, the program will support the repair, equipping, and modernization of Public Health care Facilities (PHC) and the construction of warehouses in the selected district areas. There is also a possibility of building a few new PHC facilities under Component 1, which may result in higher environmental risk rating of the project and must be confirmed during project preparation. Given the country's terrain complexity, the requirement for health facilities and construction/modernization may vary significantly. However, the infrastructure modernization operations may include the procurement of equipment, building warehouses, installation/rehabilitation of incinerators and expansion of existing health facilities. The potential environmental impacts and risks will be comprised of air pollution due to poor handling of incinerators during operation, dust, noise pollution, hazardous/ non-hazardous waste due to the construction of warehouses, impacts on public health due to poor healthcare waste management in terms of waste color coding, segregation, collection, decontamination, transportation and disposal, and occupational health and safety (OHS) related issues. The Environmental and Social Management Framework (ESMF) to be prepared, consulted upon, and disclosed prior to Project Appraisal will provide further details and guidance on how to address and manage those risks. The environmental risks associated with the implementation of the civil works will be mitigated by the application of the WB Environmental Health and Safety Guidelines (ESHGs) and Good International Industrial Practices (GIIPs) for civil works. Other risks related to public health and medical waste risks will be managed through the preparation of a generic Health Care Waste Management Plan (HCWMP) during early project implementation stage. These and all other potential environmental risks are reversible and are easily managed by the implementation of proper E&S tools and plans. The Project's Environmental and Social Commitment Plan (ESCP) and subsequent ESMF and HCWMP will have sufficient guidance and provisions to mitigate any potential environmental and social risks and impacts.

23. The project's Social Risk is rated Moderate at this stage and will be reassessed during project preparation. One of the key social challenges for the project will be to ensure social inclusion due to differentiation in geographical coverage, scale of investments, ICT absorption capacity, administrative expediency, and economy in reach-out activities. The exclusion risk shall be addressed to a large extent through a well-crafted Stakeholder Engagement Plan supplemented with an effective Information, Education and Communication campaign. Components 1 and 3 involve civil construction, some new and others repairs and rehabilitation. Rehabilitation works will lead to temporary impacts related to limited access to healthcare facilities and services. 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. Resettlement risks will be addressed through implementation of a Resettlement Framework (RF) to be prepared, adopted, disclosed, and consulted upon prior to Project Appraisal. 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 with regard to the transparency of decisions made on subproject prioritization and accountability on project



investments. These risks shall be mitigated through implementation of ESF capacity building activities, social accountability mechanisms and tools (e.g., third-party monitoring) to improve project outcomes. Labor related risks will be mitigated through the Labor Management Procedures to be prepared, adopted, disclosed, and consulted upon prior to Project Appraisal.

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