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Report No: 76397-TJ

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED GRANT

IN THE AMOUNT OF SDR 10,000,000 MILLION
(US$15 MILLION EQUIVALENT)

TO THE

REPUBLIC OF TAJIKISTAN

FOR A

HEALTH SERVICES IMPROVEMENT PROJECT

June 27, 2013

Human Development Sector Unit
Europe and Central Asia Region

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CURRENCY EQUIVALENTS

(Exchange Rate Effective: April 2013)

Currency Unit	=	Tajik Somoni (TJS)
TJS4.76	=	US$1
US$1.109	=	SDR 1

FISCAL YEAR

January 1 – December 31

ABBREVIATIONS AND ACRONYMS

ADB	Asian Development Bank
AFs	Additional Financings
ANC	Ante-Natal Care
ARI	Acute Respiratory Illness
BBP	Basic Benefits Package
CAS	Country Assistance Strategy
CBHP	Community and Basic Health Project
CG	Coordination Group
CPS	Country Partnership Strategy
CU	Country Unit
DA	Designated Account
DALY	Disability Adjusted Life Years
DHIS	District Health Information System
DOTS	Directly Observed Therapy Short Course
EC	European Commission
EMF	Environmental Management Framework
FFS	Fee for Service
FM	Family Medicine
GDP	Gross Domestic Product
GFPCR	Global Food Price Crisis Response
GiZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
GNI	Gross National Income
HH	Health Houses
HMIS	Health Management Information System
HRITF	Health Results Innovation Trust Fund
HSIP	Health Services Improvement Project
IDA	International Development Association
IDF	Institutional Development Fund
IE	Impact Evaluation
IFR	Interim Unaudited Financial Report
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
IPF	Investment Project Financing

IRR	Internal Rate of Return
ISA	International Standards on Auditing
JSDF	Japan Social Development Fund
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
M&E	Monitoring & Evaluation
MIS	Management Information System
MMR	Maternal Mortality
MoF	Ministry of Finance
MoH	Ministry of Health
MoU	Memorandum of Understanding
MTEF	Medium Term Economic Framework
NBTJ	National Bank of Tajikistan
NCDs	Non Communicable Diseases
NMS	National Micronutrient Survey
NPV	Net Present Value
OOP	Out Of Pocket
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
PAD	Project Appraisal Document
PBF	Performance Based Financing
PDO	Project Development Objectives
PDPG	Programmatic Development Policy Grant
PER	Public Expenditure Review
PFM	Public Finance Management
P4P	Pay for Performance
PFS	Project Financial Statements
PHC	Primary Health Care
PIU	Project Implementation Unit
POM	Project Operational Manual
PP	Procurement Plan
P-RAMS	Procurement Risk Assessment and Management System
PREM	Poverty Reduction and Economic Management
QI	Quality Improvement
RBF	Results Based Financing
RH	Reproductive Health
RHC	Rural Health Center
SDC	Swiss Agency for Development and Cooperation
SHASS	State Health Activities Supervision Service
SIC	State Investment Committee
SOE	Statements of Expenditure
THE	Total Health Expenditure
TDHS	Tajikistan Demographic Health Survey
TLSS	Tajikistan Living Standard Measurement Survey
TORs	Term Of References
TPHE	Total Public Health Expenditure
UNFAP	United Nations Population Fund
UNICEF	United Nations International Children Emergency Fund
USAID	United States Agency for International Development

WHO	World Health Organization
YLL	Years of Life Lost

Regional Vice President:	Philippe H. Le Houerou
Country Director:	Saroj Kumar Jha
Sector Director:	Ana Revenga
Sector Manager:	Daniel Dulitzky
Task Team Leader:	Wezi Msisha
Co-Task Team Leader:	Antonio Giuffrida

TAJIKISTAN
Health Services Improvement Project

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PAD DATA SHEET

Tajikistan

Tajikistan Health Services Improvement Project (HSIP) (P126130)

PROJECT APPRAISAL DOCUMENT

EUROPE AND CENTRAL ASIA

ECSH1

Report No.: PAD180

Basic Information			
Project ID	Lending Instrument	EA Category	Team Leader
P126130	Investment Project Financing	B - Partial Assessment	Wezi Marianne Msisha
Project Implementation Start Date		Project Implementation End Date	
31-Jul-2013		31-Jul-2018	
Expected Effectiveness Date		Expected Closing Date	
30-Nov-2013		31-Jan-2019	
Joint IFC			
No			
Sector Manager	Sector Director	Country Director	Regional Vice President
Daniel Dulitzky	Ana L. Revenga	Saroj Kumar Jha	Philippe H. Le Houerou

Borrower: Ministry of Finance			
Responsible Agency: Ministry of Health			
Contact:	Saida Jobirova	Title:	First Deputy Minister of Health
Telephone No.:	(992-372) 221-06-73	Email:	sjobirova53@mail.ru

Project Financing Data(in USD Million)					
[ ] Loan	[X] Grant	[ ] Other			
[ ] Credit	[ ] Guarantee				
Total Project Cost:	23.00		Total Bank Financing:	15.00	
Total Cofinancing:			Financing Gap:	0.00	

Financing Source	**Amount**
BORROWER/RECIPIENT	3.20
IDA Grant	15.00
Health Results-based Financing	4.80

Total	23.00

Expected Disbursements (in USD Million)

Fiscal Year	2014	2015	2016	2017	2018	2019	0000	0000	0000
Annual	0.80	1.00	3.00	3.20	3.50	3.50	0.00	0.00	0.00
Cumulative	0.80	1.80	4.80	8.00	11.50	15.00	0.00	0.00	0.00

Proposed Development Objective(s)

The Project Development Objective (PDO) is to contribute to the improvement of the coverage and quality of basic primary health care (PHC) services in rural health facilities in selected districts.

Components

Component Name	Cost (USD Millions)
Component 1: Performance Based Financing	12.80
Component 2: Primary Health Care Strengthening	6.00
Component 3: Project Management, Coordination, and Monitoring & Evaluation	4.20

Institutional Data

Sector Board

Health, Nutrition and Population

Sectors / Climate Change

Sector (Maximum 5 and total % must equal 100)

Major Sector	Sector	%	Adaptation Co-benefits %	Mitigation Co-benefits %
Health and other social services	Health	60		
Public Administration, Law, and Justice	Compulsory health finance	40		
Total		100		

☑ I certify that there is no Adaptation and Mitigation Climate Change Co-benefits information applicable to this project.

Themes

Theme (Maximum 5 and total % must equal 100)

Major theme	Theme	%
Human development	Child health	50
Human development	Health system performance	30
Human development	Injuries and non-communicable diseases	20

Total	100

Compliance

Policy

Does the project depart from the CAS in content or in other significant respects?	Yes [ ] No [X]
Does the project require any waivers of Bank policies?	Yes [ ] No [X]
Have these been approved by Bank management?	Yes [ ] No [X]
Is approval for any policy waiver sought from the Board?	Yes [ ] No [X]
Does the project meet the Regional criteria for readiness for implementation?	Yes [X] No [ ]

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment OP/BP 4.01	X	
Natural Habitats OP/BP 4.04		X
Forests OP/BP 4.36		X
Pest Management OP 4.09		X
Physical Cultural Resources OP/BP 4.11		X
Indigenous Peoples OP/BP 4.10		X
Involuntary Resettlement OP/BP 4.12		X
Safety of Dams OP/BP 4.37		X
Projects on International Waterways OP/BP 7.50		X
Projects in Disputed Areas OP/BP 7.60		X

Legal Covenants

Name	Recurrent	Due Date	Frequency
Project Coordination Group maintained	X		Yearly

Description of Covenant

The Recipient shall operate and maintain, until the completion of the Project, a Coordination Group within the MOH, responsible for the overall coordination of the Project ("CG"). Such unit shall have staff in adequate numbers and with qualifications and experience satisfactory to the Association.

Name	Recurrent	Due Date	Frequency
Oversight Committee established and maintained		20-Dec-2013	

Description of Covenant

The Recipient shall not later than 6 months from the Effective Date, establish an Oversight Committee, responsible for overseeing and implementation of Component 1 of the Project. Such Oversight Committee shall include staff from the MOH, the Ministry of Finance, and other relevant members in adequate numbers and with qualifications and experience satisfactory to the Association.

Name	Recurrent	Due Date	Frequency
District Level PBF Verification Teams established.		20-Dec-2013	

Description of Covenant

The Recipient shall not later than 6 months from the Effective Date, establish district-level PBF Verification Teams, with experience and qualifications in the health and social sectors and with terms of reference satisfactory to the Association, which will be responsible for carrying out verification of the Eligible RHC Facilities meeting the criteria referenced in the PBF Manual.

Name	Recurrent	Due Date	Frequency
Quarterly first level verification carried out.	X		Quarterly

Description of Covenant

The Recipient shall cause the District PBF Verification Teams to carry out the verification of quantity and quality of primary care services prior to the release of the PBF payments on a quarterly basis, and in accordance with the criteria referenced in the PBF Manual, and thereafter report the findings to the CG.

Name	Recurrent	Due Date	Frequency
Independent Verification Agency contracted.		29-Nov-2013	

Description of Covenant

The Recipient shall ensure that, not later than 6 months from the Effective Date, the MOH enters into a Memorandum of Understanding or contractual relationship, on the terms acceptable to the Association, with an independent verification organization or firm, acceptable to the Association, to implement independent verification.

Name	Recurrent	Due Date	Frequency
Independent Verification carried out.	X		Semi-annual

Description of Covenant

The Recipient shall ensure that, an independent verification organization or firm acceptable to the Association implements independent verification in a sample of PBF health facilities and beneficiaries, on a semi-annual basis. The semi-annual independent verification criteria shall be specified in the PBF Manual.

Name	Recurrent	Due Date	Frequency
PBF Manual and Project Operations Manual	X		Yearly

Description of Covenant

The Recipient shall ensure that the MOH carries out Component 1 of the Project in accordance with the PBF Manual and the Project Operations Manual, and Components 2 and 3 in accordance with the Project Operations Manual.

Name	Recurrent	Due Date	Frequency
Environmental Safeguards Monitoring and Implementation	X		Yearly

Description of Covenant

For purposes of implementing Component 2.2 the Recipient shall retain a construction coordinator and an environmental consultant, who, under the oversight of the Head of Construction Department of the MOH will be responsible for (a) quality assurance of the site environmental control measures and their effectiveness; and (b) coordination and reporting of the same to MOH and the Association.

Name	Recurrent	Due Date	Frequency
Independent Environmental Safeguards Assessment		04-Jun-2018	

Description of Covenant

For purposes of implementing Component 2.2 the Recipient shall ensure a third-party independent assessment is carried out eight months prior to the end of the Project life as specified in the EMF.

Name	Recurrent	Due Date	Frequency
PHC Performance Agreements entered.	X		Yearly

Description of Covenant

The Recipient shall enter into an agreement with each of the Eligible PHC Facilities ("PHC Performance Agreements"), under terms and conditions approved by the Association and set forth in the PBF Manual, setting forth the technical, administrative and fiduciary aspects of their participation in the implementation and use of funds under Component 1 of the Project.

Conditions

Name	Type
Execution and delivery of the HRITF Grant Agreement.	Effectiveness

Description of Condition

The execution and delivery of the HRITF Grant Agreement on behalf of the Recipient has been duly authorized or ratified by all necessary governmental action and all conditions precedent to its effectiveness or to the right of the Recipient to make withdrawals under it (other than the effectiveness of this Agreement) have been fulfilled.

Name	Type
Adoption of the Project Operational Manual.	Effectiveness

Description of Condition

The Project Operational Manual, satisfactory to the World Bank, has been adopted by the Recipient.

Name	Type
Disbursement from Component 1.	Disbursement

Description of Condition

No withdrawal shall be made under Category 1 and 2, unless the Recipient, through MOH, has adopted the PBF Manual satisfactory to the Association.

Name	Type
Disbursement from Component 1.	Disbursement

Description of Condition

MOH has submitted evidence satisfactory to the Association that activities of and estimated performance-based payments to the PHCs have been verified by the PBF Verification Teams in

accordance with and in compliance with the provisions of the PHC Performance Agreements and in accordance with the procedures set forth in the PBF Manual and the additional instructions referred to in Section IV A(1).

Team Composition

Bank Staff

Name	Title	Specialization	Unit
Joseph Paul Formoso	Senior Finance Officer	Finance	CTRLA
Lingzhi Xu	Senior Operations Officer	Implementation	ECSH1
Norosoa Andrianaivo	Senior Program Assistant	Senior Program Assistant	ECSHD
Adam Shayne	Lead Counsel	Legal	LEGLE
John Otieno Ogallo	Sr Financial Management Specialist	Financial Management	ECSO3
Roxanne Hakim	Sr Anthropologist	Social Safeguards	ECSSO
Dilshod Karimova	Procurement Analyst	Procurement	ECSO2
Ruma Tavorath	Senior Environmental Specialist	Environmental Safeguards	SASDI
Damien B. C. M. de Walque	Senior Economist	Impact Evaluation	DECHD
Nagaraju Duthaluri	Lead Procurement Specialist	Lead Procurement Specialist	ECSO2
Aneesa Arur	Public Health Spec.	Impact Evaluation	ECSH1
Wezi Marianne Msisha	Health Specialist	Team Lead	ECSHD
Gil Shapira	E T Consultant	Impact Evaluation	DECHD
Shodi Nazarov	Financial Management Analyst	Financial Management Analyst	ECSO3
Sarvinoz Barfieva	Consultant	Health Sp	ECSH1
Antonino Giuffrida	Sr Economist (Health)	Co-Team Leader	ECSH1
Natalia Yegorova	Counsel	Legal	LEGIA
Ayshe Muratova	E T Temporary	E T Temporary	ECCTJ

Locations

Country	First Administrative Division	Location	Planned	Actual	Comments
Tajikistan	Region of Republican Subordination	Region of Republican Subordination	X		Location: Khatlon and Sogd regions

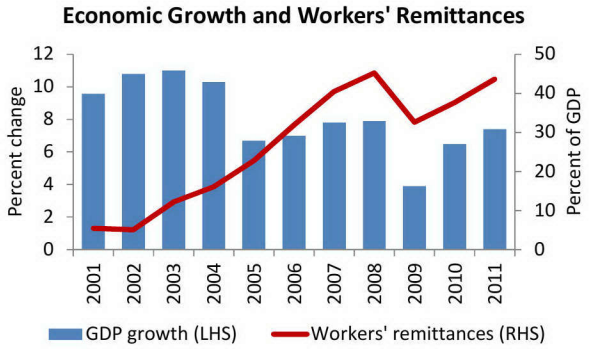
I. STRATEGIC CONTEXT

A. Country Context

1. Tajikistan is a small landlocked country in Central Asia with an estimated population of 7 million in 2009. While it is blessed with abundant water resources, contributing to its specialization in cotton production, Tajikistan is vulnerable to natural disasters and external economic conditions. Only 7 percent of its total land area is arable; high mountain ranges make communication between different parts of the country difficult, especially in winter. Tajikistan is susceptible to natural disasters and is regularly affected by floods, landslides, earthquakes, and droughts. Additionally, shortly after its independence in 1991, the country descended into a civil war that lasted until mid-1997, and which brought widespread physical damage and loss of life. These factors contribute to making Tajikistan one of the world's poorest and most vulnerable economies[1].

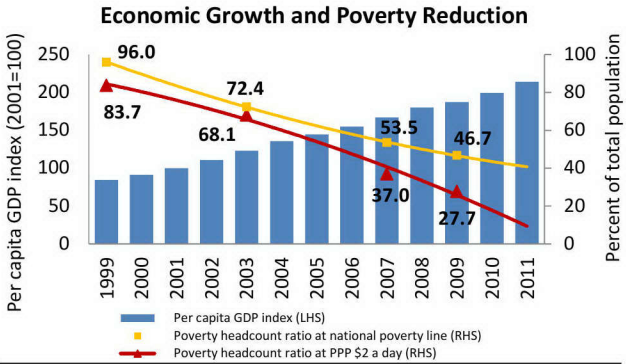
2. Strong increases in inflows of remittances, macroeconomic stability and progress in advancing structural reforms, supported robust growth and substantial poverty reduction over the last decade. Per capita gross domestic product (GDP) grew by more than 7 percent a year on average over the past decade and poverty declined from 96 percent in 1999 to 47 percent in 2009[2]. Poverty is mainly a rural phenomenon, with the rural poor accounting for 75 percent of all poor and 72 percent of the extreme poor.[3] The improvements in Tajikistan's living standards were also supported by rising inflows of donor assistance, including from the international financial institutions and higher prices for the country's key exports—aluminum and cotton—supported by the robust demand abroad. Net inflow of workers' remittances increased almost ten-fold over the past decade; from about 5 percent of GDP in 2001-2002 to almost 45 percent in 2008 and in 2011, with a temporary disruption during the recent economic crisis (Figure 1). As a result of the strong growth performance over the past decade, per capita income more than doubled in real terms and the incidence of poverty halved during this period (Figure 2).

Figure 1. Remittances became a key driver of economic growth during the last decade



Sources: Statistical Agency and National Bank of Tajikistan.

Figure 2. Income growth helped to halve the incidence of poverty in the country



Sources: Statistical Agency of Tajikistan; World Bank.

[1] The World Bank (2011). Republic of Tajikistan: 5th Programmatic Development Grant. The World Bank, Report No. 59123-TJ

[2] The World Bank (2013). Policy Note No. 1. Government Expenditures: Size Compositions and Trends. Tajikistan Policy Notes on Public Expenditures. The World Bank.

[3] The World Bank (2009). Republic of Tajikistan: Poverty Assessment. The World Bank, Report No. 51341-TJ.

B. Sectoral and Institutional Context

Health Outcomes

3. Maternal and Child Health (MCH) outcomes in Tajikistan are worse than the average in Central Asia and Caucasus regions (see Table 1). Rates of malnutrition and micronutrient deficiencies are high, with 21 percent and 53 percent of children aged 6 to 59 months respectively, stunted[4] and iodine deficient[5]. Preventable illnesses contribute to a considerable proportion of all child deaths in Tajikistan. Acute infections are the leading cause of deaths in the post-neonatal period. Acute respiratory illness (ARI), pneumonia, and acute diarrhea still account for more than 50 percent of reported child deaths within the first year of life, a pattern that has remained persistent over the last eight years until the present[6]. Physical distance to health facilities is also an important barrier for women to access antenatal and other health services, especially for those in rural areas. Furthermore, 29 percent of women in Sogd Oblast reported not seeking medical consultation during pregnancy due to the unavailability of antenatal services as a reason, a figure much higher than elsewhere in the country[7]. Improving MCH service delivery and outcomes, therefore remains a priority area for the Government of Tajikistan. The distribution of years of life lost (YLL) by causes in the year 2008 show that communicable diseases represent 62 percent of the total YLL, followed by non-communicable diseases (NCDs) with 32 percent and injury 6 percent.[8] However, cardiovascular diseases (ischemic heart disease, followed by hypertensive heart disease and cerebrovascular disease) represent the largest cause of death, followed by malignant neoplasms, respiratory diseases and diabetes mellitus.[9] The double burden of communicable and NCDs requires changes to primary health care systems, which are often established with a focus on communicable diseases but now need to place greater emphasis on preventive health care for NCDs.

Table 1. Reaching the Millennium Development Goals (MDGs) in Tajikistan

Indicators	Average Central Asia and Caucasus region (year)	Current Status (year)	MDG Target for Tajikistan 2015
MDG1: Percent of population below national poverty line (%)	22.9 (2009)[4]	47.2 (2009)[1]	41
MDG1: Children under 5 moderately or severely underweight (%) Children under 5 who are moderately or severely stunted (%)	4.38 (2010)[4] NA	16 (2012)[2] 21 (2012)[2]	NA NA
MDG4: Infant mortality (per 1,000 live birth)	30.1 (2012)[4]	34 (2012)[2]	25
MDG4: Under five mortality rate (per 1,000 live birth)	34.7 (2011)[4]	43 (2012)[2]	30
MDG4: Children 1 year old immunized against measles (%)	93.3 (2011)[4]	85.2 (2012)[2]	NA
MDG5: Maternal mortality (per 100,000 live births MDG5: Births attended by skilled health personnel (%)	50.0 (2010)[4] 97.7 (2008-2011)[4]	65 (2010)[3] 87.4 (2012)[2]	30 NA
Sources: [1]Tajikistan Poverty Update; [2] TDHS (2012), [3] Trends in Maternal Mortality: 1990-2010. WHO/UNICEF/UNFPA/WB (2010); [4] UN official site for MDGs monitoring http://unstats.un.org/unsd/mdg/Default.aspx			

[4] Source: Tajikistan Demographic Health Survey (TDHS) (2012)
[5] 2009 Tajikistan National Micronutrient Survey (NMS), UNICEF (2010).
[6] The World Bank (2011). Quality of Child Health Services in Tajikistan. The World Bank, Report No. 62870-TJ.
[7] Multisectoral Determinants of Child Mortality in Tajikistan (2010), Tajikistan Living Standards Survey (2007).
[8] WHO (2013). Tajikistan Health Profile. Accessed on April 5 2013 at http://www.who.int/countries/tjk/en/
[9] WHO (2013). Tajikistan Health Profile. Accessed on April 5 2013 at http://www.who.int/countries/tjk/en/

Health services coverage and quality

4. The coverage of priority MCH and Reproductive Health (RH) services in Tajikistan is low. Not all of the population is adequately covered by basic services such as nutrition counseling, and family planning, especially in rural areas. Only 63 percent of under-fives who had symptoms of acute respiratory infection (ARI) and 57 percent of children with fever were taken to an appropriate health care provider. Management of childhood diarrhea leaves margin for improvement. Treatment or advice was sought from a health provider for 54 percent of children ill with diarrhea. Six in ten of the children who had diarrhea were given fluids prepared from an oral rehydration solution (ORS) packet. Overall, around seven in ten children with diarrhea (72 percent) were treated with oral rehydration therapy (ORT), whether it involved a solution prepared from ORS packet or a home-prepared solution. Coverage of ante-natal care (ANC) is quite good with about 79 percent of pregnant women reporting seeing a health professional at least once for ANC, 87 percent delivered by a skilled provider and 76.5 percent of women delivering in a health facility. However, rural-urban and geographic disparities in care-seeking persist as coverage rates for key MCH services are much lower in rural than urban areas and, particularly, in Khatlon region.[10] Hypertension is poorly detected and managed in Tajikistan. Only 11 and 42 percent of the population reported to have had a heart check-up and a blood pressure test during the previous 12 months, respectively. Hypertension awareness – the share of those with high blood pressure who know that they have the condition – is at 45 percent, treatment – the share that is taking medication – is at 31 percent and control – a blood pressure reading below 140/90 among those on treatment is only 10 percent.[11]

5. At the same time, critical gaps persist in the quality of care. Despite the many efforts to improve the financing, capacity and physical infrastructure at the PHC level, in the absence of incentives to providers, these have not translated into better service quality. A recent study on the quality of child health services in Tajikistan found that the quality of PHC services provided to children is lacking in many areas, irrespective of providers' training. For instance, only 46 percent of sick children were assessed for the three basic danger signs as recommended in the Integrated Management of Childhood Illness (IMCI). Additionally, at least 60 percent of surveyed PHC facilities did not have the recommended supplies and equipment, and a significant proportion did not have essential antibiotics to treat common childhood illnesses. All these factors contribute towards the poor health outcomes seen in Tajikistan particularly for women and children.

Health Reforms

6. The pre-1990s Tajik health system adhered to the standard Soviet paradigm. The health system was centrally planned and managed, with minimum discretion allowed to local managers. The distribution of resources, number of hospital beds, and doctors per population followed the planning norms and standards developed by the Semashko Research Institute of Social Hygiene and Public Health in Moscow. The Soviet health system was highly inefficient, with a heavy emphasis on a large network of providers, a preference of hospital over primary care, and a focus on curative rather than preventive services. The financial sustainability of the Soviet Tajik health system was possible thanks to substantial budget transfers and support of the national initiatives from Moscow. The Soviet model became unaffordable due to the deep economic crisis that accompanied the early years of Tajikistan's transition from a Soviet Republic to an independent country. After independence, while the breadth of coverage stayed the same, the depth of coverage eroded, as informal out-of-pocket payments became a usual practice. The gap between de jure and de facto entitlements grew, resulting in a deep sense of

[10] Source: TDHS (2012).

[11] The World Bank (2013 In Press). Getting Better: Improving Health System Results in Eastern Europe and Central Asia. ECA-HNP. The World Bank.

disillusionment with the health system. The crisis of the sector was exacerbated by years of civil war (1993-1997).

7. In this context, a number of health financing and organizational reforms have been piloted over the last decade in Tajikistan. The main objective of the reforms was to improve the effectiveness and financial sustainability of the health sector by strengthening PHC and restructuring the oversized and unaffordable hospital delivery network inherited from the Soviet period that was absorbing an increasing share of Government resources[12]. PHC is not only the stepping stone of the health care system but also the first point of contact particularly for the rural and poor population. Key reforms that have or are being piloted in selected rayons include the introduction of a basic benefits package (BBP)-wherein a limited number of PHC services are free and some hospital and diagnostic services have formal co-payments with some exemptions; introduction of partial per-capita financing for PHC services; building managerial and financial capacity at PHC facilities; introduction of the Family Medicine (FM) model of practice; clinical capacity building of PHC physicians and nurses in FM; and rehabilitation and provision of medical equipment to PHC facilities.

8. Notwithstanding the recent reforms and investments that have led to some improvements in the delivery of PHC services, there are still several issues to be addressed. Currently, per-capita financing for PHC is applied only to the non-salary proportion of the overall budget, which represents about 10 percent of total PHC spending. The large majority of public funds are allocated to PHC facilities via line-item budgets that crystallize the status quo and do not provide incentives to quality. The investments – training, medical equipment, rehabilitation and reconstruction of facilities – have improved only a part of the PHC delivery network. The result is that overall quality of PHC services in Tajikistan remains low. Expansion to full per-capita financing for PHC services in Tajikistan is currently supported by a World Bank through an Institutional Development Fund (IDF) Grant, the European Union (UN) and WHO.

9. Financial barriers – particularly informal charges - are a key barrier to utilization of health services, particularly for the poor. Private expenditure, almost entirely represented by Out of Pocket (OOP) spending, is very high at about 73 percent (2010) of Total Health Expenditure (THE) which suggests that households carry most of the financial burden for seeking care. Informal payments for health services represent the largest part of OOPS. Analyses of utilization rates shows that the poor have many fewer visits than the non-poor and that about a third of households have family members who delay seeking help or do not seek help at all for financial reasons (Tajikistan Living Standard Measurement Survey [TLSS], 2007& 2009). In addition to financial barriers at the health facility level, rural households and those living in remote areas face considerably greater transportation costs and other costs associated with reaching health facilities.

Results Based Financing Strategies

10. Results Based Financing (RBF) strategies have achieved remarkable results in health service delivery and health outcomes in various contexts with diverse health systems-low and high income, as well as fragile states. RBF is defined as *"a cash payment or non-monetary transfer made to a national or sub-national Government, manager, provider, payer or consumer of health services after predefined results have been attained and verified. Payment is conditional on measurable actions being undertaken[13]."* Performance Based Financing (PBF) –a subset of RBF-remunerates health care providers

[12] The Bank supported this strategy through the Primary Care Project executed over the period 1999-2005 and the Community and Basic Health Project implemented over the period 2005-2013.

[13] Musgrove, P (2010). Financial and Other Rewards for Good Performance or Results: A Guided Tour of Concepts and Terms and a Short Glossary. Available: http://www.rbfhealth.org

for delivering specific services, provided the services follow explicit protocols, with a system of inspection and auditing to assure compliance and to raise quality where necessary. Performance-based payments are also provided for the teams that carry out these inspections, to motivate them to be thorough and accurate[14]. In Argentina for instance the use of performance payments in the health sector resulted in halving of infant mortality rates mostly among the poor and uninsured. In the United Kingdom, the introduction of the Pay for Performance (P4P) scheme for General Practitioners led to improved quality of care for patients with asthma and diabetes, as well as improved coverage for cervical cancer screening especially for the less affluent. Preliminary evidence from a number of developing countries also demonstrates that RBF can improve both coverage and quality of services. Experience from Rwanda – one of the most rigorously evaluated cases – found that RBF increased prenatal care quality, use of skilled delivery and child preventive care services. Giving facilities an equal amount of financial resources without the performance incentives did not achieve the same gain in outcomes in a second group of facilities included in the study. Finally, the Rwanda study also found that impacts were larger for skilled providers implying that both incentives as well as the level of health worker knowledge and skills are important to achieve the desired results.

11. Although demand side activities to motivate the population to access PHC services were considered, a feasibility assessment done in 2012 concluded that it is still too early to pilot such an approach in Tajikistan. As such the initial focus would be on supply side interventions, with possible inclusion of a demand side approach at a later stage. A combination of RBF and more traditional input-based support to build capacity and make capital investments for quality could help to improve health in Tajikistan. Capacity to respond to incentives and utilize additional resources is a pre-requisite to achieving good results. More traditional investment activities such as training to improve health workers knowledge and skills and procurement of inputs necessary to deliver good quality care, such as equipment and supplies, are also essential to build provider capacity to deliver quality health services in the Tajikistan context. Supply-side RBF that links facility payments to service outputs and quality of priority PHC services, and, also links health worker performance bonuses to facility achieved results could:

- Create incentives to improve the coverage and quality of priority PHC services
- Motivate health workers to use their skills and knowledge to achieve results
- Lower informal payments by increasing payments for health workers while increasing their accountability for results
- Improve facility functioning by giving managers autonomy to use RBF resources to procure key inputs needed to deliver health services
- Increase resources for priority PHC services by supplementing funds and in-kind support that facilities receive through the existing mechanisms and sources

12. Tajikistan's first comprehensive National Health Sector Strategy (2010-2020), highlights the provision of incentives to improve performance and quality of services as a critical aspect of the Government's health reform agenda. The Government of Tajikistan has therefore requested World Bank support to introduce the use of RBF mechanisms in the health sector to improve the quality of PHC services, particularly for mothers and children.

[14] ibid

C. Higher Level Objectives to which the Project Contributes

13. The proposed Project is consistent with the objectives of the Tajikistan's Country Partnership Strategy (CPS)[15], discussed by the Board of Executive Directors on April 22, 2010 for FY10-13, as follows:

- *Objective I: reducing the negative impact of the crisis on poverty and vulnerability; Result 2, maintain access to health services particularly for the poor and vulnerable.* As indicated in the CPS the insufficient and inequitable allocation of public resources to the health sector, together with the exodus of workers overseas due to limited job opportunities and low wages in the country, have led to an acute shortage of financial and human resources in the health sector and thus to a lowering of access to health services. The Project would contribute to improving the access of the poor to better quality health services and reducing the negative financial impacts on them through reduced demand for OOP as PHC workers' salaries would be supplemented.
- *Objective II: pave the way for post-crisis recovery and sustained development; Result 8, enhance human capital potential strengthening the quality of health care.* As noted in the CPS, the strengthening of Tajikistan's stock of human capital has significant positive implications for medium-term growth. In this regards, a critical area identified in the CPS and supported by the Project is to overcome the outdated input-based budget formation and resource allocation processes, which derive from the Soviet system and tend to maintain unaffordable hospital infrastructure capacity and prevent a shift to a more cost-effective PHC.

14. Additionally the Project is consistent with the crosscutting initiatives *identified as crucial to support CPS objectives.* These are:

- *Result 9, strengthen incentives for better performance of civil servants*: an RBF-type approach would promote and support a more efficient and effective health service delivery system;
- *Result 10, strengthen transparency and accountability in public financial managements*: by supporting citizen involvement and oversight in the delivery of public health services.

15. Finally, by focusing on gender specific health needs, such as maternal and child health, the Project would support CPS objective aimed at mainstreaming efforts to address gender disparity.

16. Since 2000, the Bank has been supporting the Government of Tajikistan in strengthening the country's health sector initially through the first health sector operation - the Primary Health Care Project (closed in 2005) and subsequently through the Community and Basic Health Project (CBHP), approved in December 2005 and financed by an initial IDA grant of USD10.0 million. Performance of the CBHP was consistently satisfactory. As a result, the Government and the Bank agreed on scaling up the project through two rounds of Additional Financings (AFs), approved in May 2009 (USD5.0 million) and July 2010 (USD3.0 million), respectively. The CBHP closed on December 31, 2012.

17. The projects supported mainly: (i) the introduction and implementation of key health sector policy reforms - including per capita financing for PHC, the BBP, health human resource strategy and health sector master plan development; (ii) improving policy development and management capacity at the central, regional health and PHC facility levels; (iii) strengthening of PHC capacity - retraining Family Medicine practitioners and rehabilitation of PHC physical infrastructure, mainly in 9 pilot districts in

[15] Report Number: 50769-TJ

Khatlon and Sogd Oblasts. The Bank's main development partners (Aga Khan Foundation, SDC, USAID, ADB, EC, WHO) have also supported the Government in implementing similar activities in different districts in the country. Since 2006, the implementation of key health sector policy actions including increase in PHC workers' salaries in 2006, maintenance of Government spending on health during the economic crisis in 2009, and Government's adoption of the Health Sector Masterplan in 2010, have been supported through the Bank's Programmatic Development Policy Grant (PDPG) series.

18. Given the problem of childhood malnutrition in Tajikistan, the Bank is also supporting the implementation of a comprehensive set of nutrition interventions at the PHC and community levels in ten districts of Khatlon Oblast, through a USD2.8 million grant from the Japan Social Development Fund (JSDF) (P122244), which became effective in November 2010. The activities are targeted to infants and young children under the age of two, and pregnant and breastfeeding women. This project builds on a previous USD4.0 million Global Food Price Crisis Response (GFPCR) grant approved in 2008 that provided food packages and micronutrient supplements to women and children, and growth monitoring equipment and training to PHC facilities in Khatlon and Sogd Oblasts. The execution of the JSDF grant is expected to be completed by September, 2013.

19. The Project would continue the Bank's support to develop the PHC system and address MCH outcomes in Tajikistan. The new Project would place a greater emphasis on the quality of service provision particularly for maternal and child health through the provision of performance-linked incentives to PHC facilities, while at the same time continuing to support capacity development and infrastructure improvements. This would contribute towards addressing health sector challenges as outlined in the CPS.

20. The Project would also contribute to the objective of eradication of extreme poverty and shared prosperity. By focusing on rural health centers, the Project is targeting the most vulnerable population. Previous studies[16] have shown that OOP spending, including unofficial payments and fees, constitute an important barrier for the poor to access health services, and a contributing factor to poverty. The hypothesis is that the impact of the Project would be pro-poor, lifting some of the barriers that the poor face in accessing health services. The impact evaluation of the PBF scheme would measure access to health services and OOP spending by wealth quintiles before and after the initiation of the PBF activities, and would assess the impact of introducing PBF by wealth quintile.

II. PROJECT DEVELOPMENT OBJECTIVES

A. PDO

21. The Project Development Objective (PDO) is to contribute to the improvement of the coverage and quality of basic primary health care (PHC) services in rural health facilities in selected districts.

Project Beneficiaries

22. The Project's main beneficiaries would be the Tajik population of selected regions who would benefit from improved PHC services. Primary health care providers would also directly benefit from the Project through performance-based incentives and capacity building.

23. Women, especially poorer rural women, would be a major direct beneficiary group as much of the Project is focused on improving maternal health services in the PHC facilities. By focusing on the underserved areas in the country, the Project would reach out to target the poorer sections of the rural

[16] The World Bank (2013). Tajikistan Health Equity and Financial Protection Report. The World Bank.

women. The focus on children's health would also indirectly benefit women who are the primary care givers and often bear the responsibility and extra work load associated with poor child health. The improvements in infrastructure would also enhance the experience for women of visiting PHC facilities due to availability of facilities like toilets, etc. On the supply side, the focus on improving training of nurses and post-graduate working experience would also target women in the area of service delivery, as the majority of nurses in Tajikistan are women.

24. Children and infants are also a specific target group that would benefit directly from the Project. The PDO indicators below show the strong focus on outcomes related to children's health. The focus on underserved rural areas would directly target children from poorer families. Improved child health would have a direct positive impact on benefitting women as well as school attendance rates. As the Project aims to strengthen PHC services generally, it is expected to promote positive health outcomes for both women and men, as well as for infants, children, working age adults and senior citizens. Further, families and the greater community would benefit indirectly as promoting the health of women and children is expected to have positive spillover effects on them.

PDO Level Results Indicators

25. The key indicators of achievement of the Project Development Objective in the selected intervention areas are as follows:

(a) Percentage of pregnant women receiving antenatal care four or more times from a skilled health provider;
(b) Contraceptive prevalence rate;
(c) Average Health Facility Quality of Care Score;
(d) Percentage of children under-five with diarrhea treated with any Oral Rehydration Therapy.

III. PROJECT DESCRIPTION

26. The proposed Project would consist of the following three components (see Annex 2 for more details):

A. Project Components

Component 1: Performance-Based Financing (USD12.8 million, of whichUSD6.0 million from IDA Grant, USD4.8 million from HRITF, & USD2.0 million Government contribution)

27. This component would support a performance based financing (PBF) pilot at the PHC level in eight rayons (or districts) in Khatlon and Sogd oblasts (regions). Under the PBF pilot, Rural Health Centers (RHCs) and their subsidiary Health Houses (HHs) would be eligible to receive a performance-based payment each quarter based on the quality and quantity of MCH and Non-communicable Diseases (NCD) services delivered. The first level verification of the accuracy of activities reported by the PHC facilities would be done quarterly by a District PBF Verification Committee. The performance-based payments would then be made to a RHC and its associated HHs, to encourage better teamwork and co-ordination. These payments would be supplementary to the funds routinely received from the public sector budget. The use of the performance-based payments would be governed by simple spending rules designed to promote provider autonomy and ensure transparency and accountability. The payments may be used for performance bonuses to facility staff and to purchase minor health facility inputs within these spending rules.

28. The development and testing of the PBF scheme is currently being financed by a separate preparation grant from the Health Results Innovation Trust Fund (HRITF). The testing of the PBF scheme in one district of Sogd oblast would continue through the first year of the project under this same grant. The expansion of the PBF scheme to the remaining seven project districts would start in the second year of the project, using Component 1 financing. An impact evaluation (IE) of the PBF scheme would be financed through a separate Bank executed grant from the HRITF. The IE would aim to build evidence on the impact and cost-effectiveness of PBF in Tajikistan (details of the IE are provided in Annex 6).

Component 2: Primary Health Care Strengthening (USD6.0 Million)

29. This component would aim to improve the capacity of Primary Health Care (PHC) providers to deliver quality services.

Sub-component 2.1 Quality Improvement (USD2.5 million)

30. The sub-component would finance the training of PHC doctors and nurses from the project districts and selected comparison districts in a six months Family Medicine training program. Nurses and doctors from all PHC facilities in the project districts and selected comparison districts would also participate in continuous medical education on clinical treatment protocols for MCH care and selected NCDs. The training would utilize recently updated and MoH approved modules developed by other development partners including GiZ, UNICEF, UNFPA, and WHO. This sub-component would also support the introduction of a collaborative quality improvement process focusing on the management of three priority areas - preliminarily acute respiratory illness, child under-nutrition, and hypertension.

Sub-component 2.2: Physical Infrastructure Improvements (USD3.5 million)

31. This sub-component would support the improvement of PHC facility infrastructure in the project districts. This would include the provision of basic medical equipment and supplies to all PHC facilities in the project districts, and some rehabilitation and reconstruction works for selected PHC facilities to ensure basic functionality. Approximately twenty-four PHC facilities in the project districts have been identified for works according to agreed criteria (i.e. only rural health centers, size of population catchment area, reasonably sound, feasible building superstructure, facilities that are currently functional and confirmed to be on state owned land, and facilities following the Health Sector Master plan recommendations). The designs for the facilities would start to be developed upon Project effectiveness, and the actual rehabilitation work would start in the second year of the Project.

Component 3: Project Management, Coordination and Monitoring & Evaluation (USD4.2 million)

32. This component would finance the expenses associated with the implementation and management of the project at the central, regional and district levels. Recurrent costs, office equipment and furniture, vehicles for project supervision, consultant salaries, travel expenses, study tours to enhance the knowledge on PBF schemes, and training for the Coordination Group (CG) members and project implementation staff at regional and district levels, monitoring and evaluation, and project audits would be supported.

B. Project Financing

Lending Instrument

33. The proposed Project uses an Investment Project Financing (IPF) instrument to be implemented over a period of five and a half years.

Project Cost and Financing (In USD million)

Table 2. Project Costs by Components

Project Components	Project cost	IDA Financing	HRITF	Government Co-financing	Share of IDA financing in total component	Share of HRITF in total component
1. Performance-based Financing	12.80	6.00	4.80	2.00	47%	38%
2. Primary Health Care Strengthening	6.00	6.00	-	-	100%	0%
3. Project Management, Coordination, and Monitoring & Evaluation	4.20	3.00	-	1.20 (in kind)	71%	0%
Total Project Costs	**23.00**	**15.00**	**4.80**	**3.20**	**65%**	**21%**

C. Lessons Learned and Reflected in the Project Design

34. **Stakeholder analysis in project preparation stage.** As the Project aims to support the introduction of a reform of performance-based financing that is new to Tajikistan, a stakeholder analysis was carried out with the support of the Poverty Reduction and Economic Management (PREM) governance team to identify potential supporters and detractors of the reform. This provides the team with crucial information on where greater efforts should be placed to ensure key stakeholders are on board with the proposed reform, and that their concerns are addressed to the extent possible throughout the project cycle.

35. **Early involvement of stakeholders.** The importance of involving key stakeholders particularly the Ministry of Finance (MoF) and development partners in the dialogue and process of introducing reforms that have an impact on sector financing is another key lesson learnt. Experience in the country has shown that failure to do this can severely delay reform efforts. As such the team has consistently had discussions with the MoF and development partners throughout the preparation period. The team has also made efforts to facilitate joint meetings between the MoF and the MoH to ensure a unified vision on the proposed reforms to be supported by the Project. The efforts have resulted in the much welcomed step of the Government commitment to provide co-financing to the Project which would cover the majority of the taxes that would be levied on the PBF incentives under the first Component. This is the first time the counterpart has co-financed the Bank financed health sector projects and reflects the level of commitment to the Project.

36. **Project implementation arrangements.** The project also reflects the lessons learned on implementation arrangements. After more than a decade of implementation of Bank financed health

projects by a stand- alone Project Implementation Unit, this Project would transition from this model to one where the MoH takes on full responsibility starting from the preparation phase and into implementation (details in next section). The experience has shown that full involvement of the line ministry in the entire project cycle ensures a higher level of ownership and accountability for results. Additionally, such an arrangement ensures better synergy between policy dialogue and the related activities being supported through the operations.

37. **Lessons on project design.** The Project takes into consideration a number of lessons on the implementation of health reforms in low and middle income countries. These include: (i) the importance of a multi-pronged approach to improving health service delivery, recognizing that training and capacity building on their own without changing the incentive system may not yield much results; (ii) the need for a specific focus on developing a quality enhancement approach that involves strengthening the role of health administrators and managers as well as training of health providers to improve service quality; (iii) focus on designing approaches that address the needs of the poor; and (iv) greater focus on increasing the accountability at all levels of the health service delivery system.

38. **Lessons from implementation of PBF in transition and low income countries.** The project has examined the experience of implementing performance-based financing schemes in a range of countries including Argentina, Armenia, Rwanda and the United Kingdom. Several lessons emerged from this: (i) PBF can improve both the coverage and quality of health services; (ii) linking additional money to performance and not just increasing money to providers is essential to success; (iii) the size and frequency of the performance incentive payments to health workers has an impact on health worker motivation; (iv) the level of health worker knowledge and skills in addition to the performance incentive payments is important for achieving results. The proposed PBF scheme for PHC facilities in Tajikistan is built on these lessons.

IV. IMPLEMENTATION

A. Institutional and Implementation Arrangements

39. The MoH is the main agency responsible for the preparation and implementation of the project. The Minister of Health has responsibility and oversight for overall project management to ensure that project resources are used as budgeted and that project development objectives would be achieved. The Coordination Group (CG) within the MoH was established in November, 2012 to be responsible for project preparation and implementation. The CG is headed by the Minister of Health and the First Deputy Minister of Health is the Project Coordinator. The CG consists of 22 members who are technical experts and heads of department/units in the MoH. The CG is supported by international and local consultants in technical, fiduciary and administrative functions (Annex 3 provides detailed description of the arrangements).

40. The First Deputy Minister of Health, who is the Coordinator, would be responsible for daily coordination and oversight of project activities. The Coordinator is responsible for representing the MoH on any project activities that require contact and communications with the Government or Government agencies as well as with the World Bank and any other agencies. In the absence of the Minister, the Coordinator is empowered to oversee project management and take decisions under the Project. An Oversight Committee would also be established with a Ministerial decree, which will give it the responsibility to oversee and the implementation of the PBF Component. The Committee would include representation from the MoH, MoF, and other relevant stakeholders.

41. Various MoH heads of departments/units and staff would carry, out relevant technical activities under the project, in addition to their routine work in MoH. Their specific responsibilities are being

discussed and their TORs would be developed and included in the Project Operations Manual (POM). Local and international consultants have been recruited to assist the CG in project preparation and implementation. The CG is not an independent legal entity. Instead it is an integrated part of the MoH, unlike the traditional Project Implementation Unit (PIU) for the previous health sector projects funded by IDA. The MoH organizational structure for implementation of the Project is presented in Annex 3.

42. *Fiduciary Arrangements*. The Accounting Unit of the MoH, assisted by two local consultants, one for financial management and one for disbursement, would be responsible for the financial management and disbursement functions, including managing the project Designated Account (DA) following the procedures outlined in the Project Operational Manual, Grant Agreement and Disbursement Letter. Financial management capacity is currently being strengthened through a Recipient-executed RBF preparation grant (TF010618) that is being implemented using similar implementation arrangement to be used for the proposed project. The Procurement Unit in MoH, assisted by a local procurement consultant, is responsible for project procurement, including preparation of the Procurement Plan (PP). The draft PP for the first 18 months of project implementation is being developed and should be finalized upon completion of the project appraisal. The CG would work closely with the relevant departments in the MoF in the implementation of the PBF scheme. The Head of Finance & Budget Planning Department in MoH and the Head of the Social Sector Budget Department in the MoF are responsible for overseeing the funds flow arrangements and related fiduciary requirements for the PBF scheme. At the local levels, the Department of Health in each project region is responsible for project preparation and implementation. To supplement capacity, consultants would be hired to assist the relevant Departments in technical, fiduciary, monitoring & evaluation, and administrative functions.

43. *Project Monitoring & Evaluation (M&E) and Project Operations Manual (POM).* M&E would be managed by the M&E Technical Officer in the CG and by a staff of the Department of Health at the local levels. They would also be supported by a local consultant on M&E. Detailed operation procedures would be developed and included in the POM. The draft POM would be ready by negotiations and would be adopted by the MoH to guide the implementation of the project, and would be updated periodically, as may be required, during project implementation. Adoption of the POM satisfactory to the Bank by MoH would be a condition for project effectiveness.

B. Results Monitoring and Evaluation

44. The PDO level and intermediate outcome indicators would be monitored using the following sources and methodologies: (a) routine reporting through the PBF Management Information System (MIS); (b) baseline and follow-up surveys; and (c) progress reports. The M&E coordinator of the MoH CG would, with the support of the local consultant be responsible for bringing together the progress reports, monitoring the key performance indicators and results, and communicating with the World Bank on progress.

45. Data collection and reporting for the Project would be harmonized with country systems. The PBF MIS, which is the data source for many PBF-related indicators, would leverage on-going efforts to upgrade the country's Health Management Information System (HMIS). District Health Information System 2 (DHIS 2), an open source and web-based software package, is being customized with EU support to develop a model HMIS for Tajikistan that would offset many of the current drawbacks of the existing HMIS. Efforts would be made to ensure compatibility of the PBF MIS software modules with the new DHIS 2 based national HMIS for Tajikistan.

46. PBF MIS data would be reported through the routine paper based reporting process and verified prior to their inclusion in the PBF MIS database. Facilities would self-report PBF indicators on the volume of services delivered through routine reporting channels. These data would be verified during the

first level quarterly verification process prior to the release of PBF payments, and quality of care would also be assessed at the same time using a structured quality checklist. These verified data would be included in the PBF MIS. The currently proposed DHIS 2 based HMIS is intended to be paper-based at the PHC facility level. The project is exploring the possibility of using mobile phone technologies or other low cost technologies to facilitate reporting at the facility level. These approaches would be piloted in one of the pilot districts (Spitamen) during the first year of the project. A decision would then be taken on whether to incorporate them in the remaining seven project districts starting in the second year of the project implementation.

47. The semi-annual independent verification is proposed to be led by UNICEF and would be implemented every six months on a sample of PBF facilities. The goal would be to ensure that facilities reported achieved results accurately, and to identify and penalize instances of falsified reporting and fraud. At a minimum, the independent verification would encompass the following aspects: (i) home visits to a randomly selected sub-sample of PBF beneficiaries to verify receipt of services; (ii) checking facility records to assess concordance between reports of PBF performance and facility registers; (iii) verifying with staff that payments were received; and (iv) verifying facility quality scores. Results from the semi-annual independent verification would be provided to the MoH for their review and acceptance.

48. The project would also include a prospective IE which would be financed through a separate HRITF Bank-executed grant. The Impact Evaluation (IE) would seek to ascertain: (i) the impact and cost-effectiveness of the PBF model implemented in Tajikistan; and (ii) whether PBF is more effective if implemented in conjunction with additional low cost interventions that address potential constraints to PBF effectiveness. The two interventions under consideration are: (a) Collaborative Quality Improvement, i.e., a facilitated quality improvement approach focused on common provider-identified objectives with performance feedback and competency training for provider Quality Improvement teams; and (b) Citizen Report Cards, i.e., providing local communities with information on the performance of their health facility by disseminating a facility report card that benchmarks the performance of their local facility against an appropriately chosen reference. The quality improvement intervention responds to policy concerns that performance incentives may not produce the desired improvements if providers lack the necessary competencies and knowledge. The citizen report card attempts to improve the effectiveness of PBF by increasing the accountability of health facilities to their local constituents. Clusters of health facilities in each phase two project district, with a cluster defined as a single RHC plus corresponding HHs, would be randomly assigned to one of three arms: (1) PBF only; (2) PBF plus Collaborative Quality Improvement; (3) PBF plus Citizen Report Card. In addition, for the purpose of the IE, comparison districts where PBF would not be implemented are to be selected. Clusters of health facilities, defined as above, in each of these districts would be assigned to three arms: (1) Business as usual; (2) Collaborative Quality Improvement; and (3) Citizen Report Card.

49. The IE would focus only on the seven roll out project districts and on the comparison districts. The PBF testing rayon-Spitamen would not be included in the IE sample. At a minimum, baseline and end-line (end of project) household and health facility surveys would be implemented in all project districts and comparison non-project districts to measure impact. The questions to be addressed by the IE, and the design of the IE, were discussed and finalized with stakeholders in Tajikistan at an Impact Evaluation workshop held on May 6-7, 2013. The design may, however, be further modified at a later stage based on further feedback or implementation experience in Spitamen rayon.

C. Sustainability

50. The sustainability of the HSIP has been assessed considering three aspects: first, the Government's ownership of the program and of the policies and investment priorities therein embedded; second, evidence of sufficient fiscal space for the health sector to sustain the investment supported by the project

beyond its completion; and third, the technical soundness of policy and investment choices embedded in the HSIP.

51. *Government's ownership of the program.* The first element supporting Government's ownership of the program is the approval in 2010 of the first comprehensive National Health Sector Strategy 2010-2020 that considers the provision of incentives to improve performance and quality of services as a critical aspect of the Government's health reform agenda. Additionally, the Strategy strongly emphasizes the need of investments to strengthen PHC and to expand the FM model supported by the HSIP, and identify MCH and NCD as key national health priorities. Government's ownership of the program is further demonstrated by the decision to establish a Coordination Group (CG) in the MoH in late 2012 for the preparation and implementation of the project under the direct leadership of the Minister of Health. In fact, the Minister himself has responsibility and oversight for the overall Project while the First Deputy Minister is the Project Coordinator and is responsible for daily coordination and oversight of project activities. Finally, the Government's commitment to provide co-financing to the Project to cover the majority of the taxes that would be levied on the PBF incentives under the first Component further reflects the level of commitment, as this represents the first time for counterpart co-financing to Bank financed health sector projects.

52. *Fiscal space to sustain the investment supported by the HSIP beyond its completion.* Total public health expenditure (TPHE) in Tajikistan reached about USD118.73 million in 2011. Even if TPHE in Tajikistan is still low by international comparison, it has increased over the 2007-2011 period from 1.3 to 1.82 percent of GDP, which represents a 40 percent increase in only four years. The overall prospect of the fiscal space for health in Tajikistan is quite positive considering that: (i) GDP is expected to grow by 7 percent per year over the 2012-2018 period; and (ii) the current low level of resources allocated to the health sector provides space for re-prioritization of health spending within the Government budget as demonstrated by the rapid increase of TPHE as a percentage of GDP over the last four years[17]. Public health expenditure in Sogd and Khatlon oblasts has increased at a faster pace, from 0.49 of the national GDP in 2007 to 0.85 percent of GDP in 2011, which represent an annual increase of about USD10M. Therefore, the country's future fiscal space should allow the sustaining of the investment supported by the HSIP beyond its completion and potentially to expand the interventions to additional districts (see Annex 8 Economic and Fiscal Analyses).

53. *Technical soundness of policy and investment choices.* Two factors provide cause for optimism in this regard: first, the commitment and capacity of the Government to guarantee access to PHC and MCH services in particular; second, that the National Health Sector Strategy 2010-2020 itself focuses on the key areas, namely, continuing pro-poor reforms to improve efficiency, equity and quality of care, and critical issues such as expansion of full per-capita financing, introduction of incentive payments and expansion of FM model in PHC. Additionally, the independent third-part monitoring of results, which is a key factor in determining disbursements under the PBF component, would help MoH and its partners to stay on a path that is consistent with the HSIP.

V. KEY RISKS AND MITIGATION MEASURES

A. Risk Ratings Summary Table

Risk	Rating
Stakeholder Risk	Moderate

[17] See: The World Bank (2013). Policy Note No. 2. Review of Public Expenditures on Health. Tajikistan Policy Notes on Public Expenditures. The World Bank.

Implementing Agency Risk	Substantial
- Capacity	Substantial
- Governance	Substantial
Project Risk	
- Design	Moderate
- Social and Environmental	Moderate
- Program and Donor	Substantial
- Delivery Monitoring and Sustainability	Substantial
Overall Implementation Risk	Substantial

B. Overall Risk Rating Explanation

54. The overall project risk rating is rated as "**substantial**". This is the first time the MoH is going to implement a PBF scheme and the capacity at central and local levels is weak. The challenges in the first two years seem to be associated with the lack of qualified staff to test out the PBF scheme and make the fund flow mechanism work smoothly and without delays in payments. These risks are being mitigated by hiring an international consulting firm to assist the MoH with the design, testing, refining and implementing the project in pilot districts during the first two years of the Project, learning from best practices in various countries and workshops to share experiences among project districts, and frequent Bank support missions to the field. The project design also provides flexibility for improving the design and fine tuning the PBF scheme as project implementation continues.

55. Stakeholder risk is rated as "moderate". The introduction of the new PBF reform could face delays from poor coordination between the two key Ministries- MoH and MoF. However, this would be mitigated by maintaining the regular joint ministerial and development partner discussions that were initiated during the project preparation process. There are also risks related to possible misreporting of data by the PHC facilities. The verification processes would help to identify any possible misreporting. The contracts between the MoH and PHC would clearly state the penalties for misreporting, and sanctions would be applied to deter such instances.

56. The social and environmental risks are rated "moderate" due to the planned reconstruction and rehabilitation of 24 PHC facilities. An Environmental Management Framework (EMF) has been prepared for the project. Prior to the start of civil works, individual site specific Environmental Management Plans (EMPs) would be prepared to guide the construction processes and ensure minimizing of negative environmental impacts. Consultations will be held with neighboring communities prior to construction and regular systems for monitoring of worker safety and construction quality has been defined in the EMF. Program and donor risks are rated as "substantial" as the PBF reporting mechanism will build on the new HMIS system supported by the EU, and currently undergoing tested. There is a high risk that the testing phase and customization of the PBF modules could be delayed. The Bank team would work closely with the EU project and the MoH to ensure efforts are coordinated, and would also have an HMIS specialist on the team to support the MoH in this process.

57. Delivery, monitoring and sustainability risk is rated "substantial". The rehabilitated PHC facilities might not be well maintained. The PBF pilot scheme may not be continued beyond the life of the Project if results are not positive, and this could demotivate the health workers. However, this would be mitigated by ongoing policy dialogue with the Government during the project implementation. Also the Impact Evaluation findings would help to provide evidence on the effectiveness of the program.

VI. APPRAISAL SUMMARY

A. Economic Analyses

58. The economic analysis of the project has been conducted in light of following three questions: (i) What is the project's development impact?; (ii) Is public sector provision or financing the appropriate vehicle?; and (iii) What is the World Bank's value added?

59. *The development impact of the project.* The costs and benefits of the project have been estimated over the 2014–2030 period. The Project is expected to save over 4,400 disability-adjusted life years (DALYs) in 2018 and 1,430 in 2030 for a total of 36,630 DALYs over the 2014–2030 period. The main direct benefit of the project derives from the economic value of averted DALYs. The baseline and most conservative scenario results in a net present value (NPV) of nearly USD7.7 million and a 17.1 percent internal rate of return (IRR). NPV and IRR analyses were quite sensitive to the value of a DALY. Increasing the value of a DALY from 1 to 3 times GDP per capita raises the IRR from 17.1 to 72.2 percent. With valuation of life near to what is used in U.S. studies, the project IRR is unusually high. In contrast, the IRR was not very sensitive to the deflator (inflation) rate or to the discount rate for DALYs averted. Alternative scenarios and their effect on the Project's economic performance are presented in the sensitivity analysis (see Annex 8 Economic and Fiscal analyses).

60. *Rationale for public involvement.* In Tajikistan the right to health care is a constitutional right that should be ensured through free provision of medical services in public institutions.[18] Many factors have delayed the development of private practice in rural Tajikistan. Most importantly, the vast majority of the rural population has very limited resources available for medical services. The investment in private health facilities is therefore economically not viable, and there are very limited incentives for doctors to open private practices. Therefore, the alternative of relying on private health services providers is not currently feasible in rural Tajikistan.

61. *Rationale for the World Bank's involvement*. The World Bank's value added in the proposed project is two-fold. First, the Bank's long-term engagement in the health sector through the Primary Health Care Project and the Community and Basic Health Project generated a deep knowledge of the sector and its development challenges that informed the preparation of the proposed operation. Second, the presence at the Bank of the HRITF that has the objective of supporting result-based financing (RBF) programs in low-income countries. Thanks to the generous support provided by the HRITF, the World Bank has been able to: (i) include in the preparation of the proposed operation, global expertise and best practices in the design and implementation of RBF solutions in the health sector; (ii) provide technical assistance and a recipient-executed grant to support project preparation; (iii) leverage the IDA allocation to the project with additional grant financing; and (iv) include in the design of the project a rigorous IE of the PBF intervention.

B. Technical

62. The technical design of the project is based on the growing global evidence that transforming the input-based health systems to results-based systems can change the persistent under-performance of countries' health services. In Tajikistan, poor health outcomes have persisted despite substantial investments and reforms implemented over the last decade. RBF has emerged as a widely implemented strategy to strengthen access to and supply of quality health services through the adoption of financial or other rewards as an alternative to the traditional input-based approach.[19] The PBF approach that would

[18] Article 38 of 1994 Constitution of the Republic of Tajikistan.
[19] Source: Result-based financing for health http://www.rbfhealth.org

be introduced in Tajikistan has benefited from the global expertise and experiences provided by the HRITF.

63. The design of the project was informed by a set of studies financed by the Rapid Social Response Trust Fund, which included: (i) an assessment of the capacity of rural health centers and health houses located in Sogd and Khatlon oblasts to deliver basic MCH and nutrition services; and (ii) primary data collection and analyses using quantitative and qualitative methods, to identify current patterns of MCH and nutrition service use, barriers to their use, and the feasibility of demand and supply-side RBF interventions to improve service uptake in Sogd and Khatlon among the poor and vulnerable households. The UNICEF Tajikistan Country office has been working together with the World Bank on the development of the independent verification mechanism of the PBF component and to develop a methodology for the bottleneck analyses of MCH services at national, regional and in the selected PBF districts.

64. The design of the project also benefited of additional studies developed in collaboration with the Poverty Reduction and Economic Management (PREM) department, such as: (i) a Policy Note on Public Health Expenditure developed as part of the World Bank Programmatic Public Expenditure Review (PER); (ii) a Political Economy Analysis of Rural Health Stakeholders in Tajikistan; and (iii) a feasibility analysis of citizen report card for health sector monitoring. Finally, the lessons learned from the previous health projects in Tajikistan – particularly the CBHP and the PHC project – and the relevant experiences of Development Partners working in Tajikistan health sector were taken into account and incorporated into the final design of the project.

C. Financial Management

65. Assessment of the financial management arrangements for the HSIP was conducted in February, April and May 2013 in Dushanbe and RHCs in the Khatlon Oblast (Yavan) and Sogd Oblast (Spitamen and Ghonchi). The objective of the assessment was to determine whether the agencies that would be involved in implementing the HSIP, namely, the MoH and the pilot RHCs, have acceptable financial management arrangements for the Project implementation. The review covered the system of accounting, budgeting, flow of funds and accountability mechanisms, including of labor related payments at the local level, financial reporting, auditing, and internal controls at the central MoH and the rural health facilities. The financial management arrangements are acceptable if they are considered capable of recording correctly all transactions and balances, supporting the preparation of regular and reliable financial statements, safeguarding the assets, and are subject to auditing arrangements acceptable to the Bank. The focus of the assessment was on the use of the country's systems of budgeting, funds flow, accounting, reporting, internal control and audit with a view to determining the elements of the country's Public Finance Management (PFM) system that can be relied on during implementation of the project, and to identify fiduciary risks associated with the flow of funds under Component 1 of the Project. This entailed visiting the budgeting, accounting & reporting and internal audit units in the MoH, the Treasury Department of the MoF as well as the accounting and reporting units in the rural health facilities.

66. Overall, the financial management arrangement of the HSIP is currently assessed to be ***Moderately Satisfactory.*** From a financial management perspective the proposed Project is considered *Substantial Risk*, particularly given weaknesses in the country systems, including the MoH accounting system, which is currently manual and without in-built controls, and staff capacity at the local RHCs, as well as the potential delays that may be experienced with the flow of funds from the designated account to be maintained at the National Bank of Tajikistan and channeled to the beneficiaries through the treasury system. The manual accounting system maintained by the MoH and PHC facilities is susceptible to errors, and the widespread use of cash payments by the rural health care facilities raises significant risk

of misuse of funds. The Project would also be implemented in an environment of high perceived corruption with significant involvement of local health care facilities that have limited capacity for financial management. However, adequate mitigating measures are being implemented, including automating the project accounting system of the MoH, hiring of FM and Disbursement consultants to support the MOH accounting staff, provision of additional training to accounting personnel to make them fully functional with the accounting software and streamlining of the flow of funds through the Treasury system. The FM consultants would provide additional staff capacity in the accounting department of the MoH to cope with the expected increased workload from the HSIP Grants, and other activities financed by other donors. Currently FM and Disbursement Consultant have been hired and are supporting the unit in establishing effective financial management system to be used by the project. Hardware and software for the automation of the accounting system have been procured and installed; and testing to ensure the system is fully operational is expected to be completed by June 30, 2013.

67. Upon satisfactory implementation of the action plan in Annex 3, by effectiveness, the financial management arrangements established by the MoH for the Project will be capable of completely and accurately recording all transactions and balances, and support the preparation of regular financial statements that would be submitted to Bank regularly and on time. Internal control systems and procedures established by the MoH and health care agencies would be strengthened to ensure reliability of accounting records, and safeguarding the projects' resources and assets. This would include: (i) describing the internal control procedures in the Project Operational Manual (POM) to be approved and adopted before project effectiveness; (ii) incorporating PBF specific information in the PBF Manual to be adopted prior to disbursement from Component 1; and (iii) improving capacity of the internal audit unit to monitor implementation of the fiduciary risk mitigation and capacity development measures to be developed as part of the overall improvement of the fiduciary environment in the MoH and the pilot health care facilities.

D. Procurement

68. *General:* Procurement for the proposed Project would be carried out in accordance with the World Bank's "Guidelines: Procurement of Goods, Works and Non-Consulting Services under IBRD Loans and IDA Credits & Grants by World Bank Borrowers" dated January 2011 (Procurement Guidelines); and "Guidelines: Selection and Employment of Consultants under IBRD Loans and IDA Credits & Grants by World Bank Borrowers" dated January 2011 (Consultant Guidelines) and the provisions stipulated in the Financing Agreement. The World Bank Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credit and Grants dated October 15, 2006 and revised on January 2011, would also apply.

69. The Procurement Capacity of the MoH was assessed using Procurement Risk Assessment and Management System (P-RAMS). The main procurement risk related to the Project would be potential delays due to internal coordination within the MoH, high turnover of procurement staff and low capacity. Delayed evaluation and reduced accountability due to involvement of the State Investment Committee (SIC). To mitigate these risks, further procurement training would be provided and the Procurement Unit would closely monitor the procurement implementation and coordinate with other departments within MoH. The Bank's regional procurement team would provide advice and assistance on a regular basis. Currently an experienced local procurement consultant is providing support to the MoH and would continue to do so during implementation.

70. Procurement Guidelines would also apply to the non-salary expenditure out of the performance-based payments (i.e. the 30% percent portion of performance-based payments). However, most of the procurement activities are going to be small (contracts would be below the National Competitive Bidding threshold, and further most of the goods contracts would be below the shopping threshold).

Therefore, as part of Project Operations Manual, the Bank would assist the MoH to develop the "Procurement Manual for Health Facilities" basing the conditions on acceptability of National Competitive Bidding procedures as stipulated in the Financing Agreement and Bank Guidelines primarily addressing the principles of efficiency, economy, transparency, competition and fairness.

E. Social (including Safeguards)

71. The proposed Project activities on strengthening of overall PHC services are expected to promote positive health outcomes for both women and men, as well as for infants, children, working age adults and senior citizens.

72. Women, especially poor rural women would be a major direct beneficiary group as much of the Project is focused on improving MCH services in PHC facilities located in rural areas in selected regions of the country. The improvements in infrastructure would also enhance the experience of visiting the PHCs for women due to availability of facilities like toilets, waiting areas etc. On the supply side, focus on improving nurse training and post-graduate experience would also target women in the area of service delivery, as the majority of nurses in Tajikistan are women.

73. Children and infants are also a specific target beneficiary group that would benefit directly from the Project. The PDO indicators show a strong focus on outcomes related to children's health. The focus on underserviced rural areas would directly target children from poorer families. Improved child health would have a direct positive impact on benefitting women who are the primary care givers, as well as on school attendance rates. Families and the wider community would also benefit indirectly from the positive spillover effects from due to the expected improvements in health of women and children.

74. The project M&E would disaggregate data to the extent feasible to capture the impacts on women and children as well as the elderly.

75. The project would carry out refurbishment and repairs of approximately twenty-four PHCs. Since most are minor repairs on existing sites and there is no new land acquisition, no involuntary resettlement impacts are envisaged and hence OP 4.12 is not triggered for this project. In any case, prior to carrying out of any civil works, an environment and social screening would be done. In the event that any impacts related to land acquisition or restriction of access to services, assets or resources are seen, the CG would immediately notify the World Bank and no civil works would proceed until appropriate mitigation instruments are prepared.

F. Environment (including Safeguards)

76. The sub-component 2.2 *Physical Infrastructure Improvements* involves the re-construction and rehabilitation of physical infrastructure of Rural Health Centers, to upgrade them to basic levels of functionality to be able to provide satisfactory health services in accordance with the Project Development Objective. Twenty-four PHC facilities have been identified for refurbishment based on agreed criteria and the facilities. While there is no foreseen expansion of the constructed area or substantial increase of capacity, the current situation of the facilities are quite degraded and would need significant rehabilitation and civil works to improve availability of basic utilities and services including water, sanitation and electricity and healthcare waste management.

77. An environmental assessment of sample facilities indicates that none of them have access to safe and adequate drinking water. Water is brought in buckets from neighborhood residential areas and boiled prior to use. Sewage systems are inadequate, and are basically non-concrete pits dug out in the RHC backyards. Once filled, such pit lavatories are covered up and new pits are dug, resulting in potential

gradual soil and groundwater contamination. Most RHCs have restricted power access and utilize potbelly stoves which are expensive to operate and inefficient with poor heat retention. The use of fine blend coal also results in harmful indoor air emissions and charcoal-black deposition which is harmful for staff and patients. Due to the shortage of coal, firewood is used as an alternative, resulting in degradation of neighboring bushes and forests. Most of these old building structures contain asbestos, which would require sound management during dismantling and disposal. Waste disposal facilities are inadequate, and all categories of healthcare waste are collected in first aid boxes and burned in pits located within the premises. New pits are routinely dug, after others are filled, further resulting in soil and air contamination (mercury, dioxins and furans) and hazards due to scattered sharps. There is no foreseen substantial increase of quantity of medical waste, or change in waste types or composition, but the new constructions will address environmentally sound ways of disposing infectious waste generated from healthcare services.

78. The nature of the civil works and the need for sound environmental management necessitates that OP 4.01 be triggered and that the project be classified as Category B. Based on the assessment of sample facilities, the MOH has prepared an EMF, which has been consulted with key stakeholders and disclosed prior to Appraisal. Based on the feedback from consultations and internal reviews, the EMF has been revised and the final document has been disclosed prior to Negotiations.

79. The EMF defines critical mitigatory measures to be taken to address environmental impacts prior to and during construction phase. These include issues related to design, water supply, sanitation and sewerage, power supply and waste management including construction debris and asbestos. Worker safety during construction and occupational safety and healthcare waste management during facility operations are also addressed in the EMF. Site-specific Environment Management Plans will be prepared and approved prior to commencement of civil works at each site and EMP requirements will be included into bid contracts for civil works. The EMPs will be disclosed and consulted with all neighborhood communities around the project site, prior to commencement of works. The community will also be consulted with regard to alternative location for continuation of RHC services during the time of construction and restoration. In addition to regular monitoring and supervision requirements during and after construction, the EMF requires a third-party independent assessment to be carried out eight months prior to the end of the Project life.

80. The MOH will hire a Construction Coordinator and an Environmental consultant who under the oversight of the Head of Construction Department in the MoH would be responsible for overall coordination and reporting to MOH and the Bank. They will be responsible for quality assurance of the site environmental control measures and their effectiveness and will have a right to suspend or amend construction works if there is an unforeseen risk or potential harm to the environment or if the EMP is not been implemented satisfactorily. The Project has allocated sufficient budget for implementation of EMP measures and related training and capacity building for good occupational practices and environmental measures for operational phase of healthcare services.

Annex 1: Results Framework and Monitoring

Tajikistan
Health Services Improvement Project

Results Framework[20]

Project Development Objective

The project Development Objective is to contribute to the improvement of the coverage and quality of basic Primary Health Care (PHC) services in rural health facilities in selected regions

PDO Level Results Indicators	Core	Units of measurement	Baseline	Cumulative Target Values					Frequency	Data Source/ Methodology	Responsibility for Data Collection	Description (Indicator definition etc.)
				Year 1	Year 2	Year 3	Year 4	Year 5	Year 6*				
Percentage of pregnant women receiving antenatal care four or more times from a skilled health provider		% (and number)	79.2% Sogd 39.2% Khatlon [World Bank 2012]	79.2%' Sogd 39.2% Khatlon				85%- Sogd 45%- Khatlon		Household Survey: Y1 & Y5	Household Survey	MoH Coordination Group, Oblast and rayon health departments	Number of pregnant women in project districts receiving ante natal care four or more times from a skilled provider Numerator: Number of pregnant women in project districts receiving ante natal care four or

[20] PBF related indicator targets would be determined during the piloting of the PBF scheme in year 1 of the project.

													more times from a skilled provider Denominator: Total number of pregnant women in project districts To be disaggregated for Sogd and Khatlon Data source for percentage: HHS; Data source for number: PBF MIS
Contraceptive Prevalence Rate		% (and number)	30.7% Sogd 22.9% Khatlon [Source: DHS 2012]	30.7% Sogd 22.9% Khatlon				35% Sogd 27% Khatlon		Household Survey: Y1 & Y5	Household survey	MoH Coordination Group, Oblast and rayon health departments	Number of women in project districts aged 15-49 years who are currently using a modern method of Family Planning Numerator: Number of women in

													project districts aged 15-49 years who are currently using a modern method of Family Planning Denominator: Number of women in project districts aged 15-49 years who are currently married To be disaggregated for Sogd and Khatlon Data source for percentage: HHS; Data source for number: PBF MIS
Average Health Facility Quality of Care Score		Mean quality score (Quality score ranges from 0-	To be estimated						To be estimated	Health Facility Survey: Y1 & Y5	Health Facility Survey	MoH Coordination Group, Oblast and rayon health departments	Composite Health Facility Quality Score covering domains of:

		100)											staffing, functional equipment and drugs/ supplies available and criterion based audit. Each facility would be scored on each item in the index to create a facility score that ranges from 0-100. The mean for all facilities would then be computed. To be disaggregated for Sogd and Khatlon

Percentage of children under-five with diarrhea treated with any Oral Rehydration Therapy		%	79.2% Sogd 68.2% Khatlon [Source: DHS 2012]	79.2% Sogd 68.2% Khatlon				85% Sogd 74% Khatlon		Household survey: Y1 & Y5	Household survey	MoH Coordination Group, Oblast and Rayon Health Departments	Number of children under-five with diarrhea in project districts visiting Rural Health Centers or Health Houses treated with any ORT

													Numerator: Number of children under-five with diarrhea in project districts visiting Rural Health Centers or Health Houses treated with any ORT Denominator: Number of children under-five with diarrhea in project districts visiting Rural Health Centers or Health Houses To be disaggregated for Sogd and Khatlon Data source for percentage: HFS; Data source for number: PBF MIS
Intermediate Level Results Indicators	**Core**	**Units of measurement**	**Baseline**	**Cumulative Target Values**						**frequency-cy**	**Data Source/ Methodology**	**Responsibility for Data Collection**	**Description (Indicator definition etc.)**
				Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**				
			Component 1: Performance Based Financing										

Number of eligible health facilities in which PBF is initiated		Number	0	TBD	TBD	TBD	TBD	TBD	TBD	Semi-annual (PBF MIS database)	PBF MIS database, official medical statistics	MoH Coordination Group, Oblast and Rayon Health Departments	Number of Rural Health Centers that have received first PBF payment To be disaggregated for Sogd and Khatlon
Percentage of Primary Health Care facilities eligible for PBF payments who received timely PBF payments in the preceding quarter		%	0	60%	80%	100%	100%	100%	100%	Semi-annual (PBF MIS database)	PBF MIS database, official medical statistics	MoH Coordination Group, Oblast and Rayon Health Departments	Numerator: Number of Rural Health Centers in project districts who received quarterly PBF payment within [TBD] days of quarter ending in the most recently completed quarter Denominator: Number of Rural Health Centers in project districts who were eligible for payment based on first verification report (ex-ante verification) To be disaggregated for Sogd and Khatlon
Number of independent		Number per year	0	1	2	8	8	8		Semi-annual	PBF MIS database,	MoH Coordination	Number of independent

verification visits completed per schedule									8	(PBF MIS database)	official medical statistics	Group, Oblast and Rayon Health Departments	verification reports completed by third party verification agency as scheduled, i.e., one report per rayon every six months To be disaggregated for Sogd and Khatlon
Percentage of hypertensive adults who are currently receiving anti-hypertensive treatment		%		TBD				TBD		Household Survey: Y1 & Y5	Household Survey	MoH Coordination Group, Oblast and Rayon Health Departments	Numerator: Number of adults (18+) in project districts who are currently on anti-hypertensive treatment Denominator: Number of adults in project districts who are hypertensive Disaggregated within Sogd and Khatlon respectively by age: (1) 18-39 years; (2) 40+ years
Percentage of hypertensive patients who are		% (and number)		TBD	TBD	TBD	TBD	TBD		Semi-annual	PBF MIS, official	MoH Coordination Group, Oblast	Numerator: Number of

receiving correct anti-hypertensive treatment per protocols			TBD						TBD	(PBF MIS database)	medical statistics	and Rayon Health Departments	adult hypertensive patients (18+) at project facilities who are currently receiving correct anti-hypertensive treatment per clinical protocols Denominator: Number of adult hypertensive patients in project facilities; Disaggregated within Sogd and Khatlon respectively by age: (1) 18-39 years; (2) 40+ years
Number of pregnant/ lactating women and/ or children under age 5 reached by basic nutrition services	x ☐	Number	0	TBD	TBD	TBD	TBD	TBD	TBD	Semi-annual (PBF MIS database)	PBF MIS database, official medical statistics	MoH Coordination Group, Oblast and Rayon Health Departments	Number of pregnant or lactating women or children under age 5 years in project districts reached by growth monitoring, nutritional counselling or demonstration services

													supported by the Project To be disaggregated within Sogd and Khatlon by: (i) Pregnant/ lactating women; (ii) Children under age 24 months; (iii) Children age 24 months to 5 years
			Component 2 – Primary Health Care Strengthening										
Health personnel receiving training	x ☐	Number	0	TBD	TBD	TBD	TBD	TBD	TBD	Semi-annual (PBF MIS database)	PBF MIS database, official medical statistics	MoH Coordination Group, Oblast and Rayon Health Departments	This includes the following: (i) Doctors and nurses in project and comparison districts who have received Family Medicine training; (ii) Doctors and nurses who have received training on Non Communicable Disease protocols; (iii) Doctors and nurses who have received training on Maternal and Child Health protocols; (iv)

													Primary Health Care managers and supervisors trained on quality supervision; (v) Staff trained on PBF supervision, verification and implementation To be disaggregated within Sogd and Khatlon by (i) to (v) listed above
Number of health facilities constructed, renovated and/ or equipped	x ☐	Number	0	3	6	6	6	24	24	Semi-annual (PBF MIS database)	PBF MIS database, official medical statistics	MoH Coordination Group, Oblast and Rayon Health Departments	Number of Rural Health Centers and Health Houses in project districts constructed, renovated or equipped in accordance with sound environmental requirements To be disaggregated for Sogd and Khatlon
		Component 3: Project Management											
Number of project districts in which		Number	0	1	3	8	8	8		Semi-annual	PBF Progress report	MoH Coordination Group, Oblast and Rayon	Number of districts in which the PBF MIS is used to

PBF MIS is operational									8			Health Departments	transmit PBF data electronically from districts to MoH CG
Report on evaluation of pilot experience completed and action plan for the roll-out prepared		Yes/ No	No	No	Yes	N/A[21]	N/A	N/A	N/A	N/A	PBF Progress report	MoH Coordination Group, Oblast and Rayon Health Departments	"Yes" response indicates that both evaluation report and action plan for roll out has been completed

[21] N/A- not applicable

Annex 2: Detailed Project Description

Tajikistan: Health Services Improvement Project

1. **Component 1: Performance-Based Financing (USD10.8 million, of whichUSD6.0 million from IDA Grant and USD4.8 million from HRITF, & USD2.0 million Government contribution).** This component would support a pilot of performance based financing (PBF) at the primary health care level. In order to address the challenges of limited MCH and NCD coverage and quality gaps the project takes an innovative financing approach to provide quarterly payments to Rural Health Centers (RHC) and their subsidiary Health Houses (HH) based on their performance on a set of agreed MCH and NCD services. The Ministry of Health would be the Purchaser of services from the PHC facilities in the PBF scheme. The separation of purchaser and provider functions is ensured, since local district administrations are responsible for the provision of health services provided by RHCs and HHs in Tajikistan. Operational details on the PBF scheme would be specified in the PBF Manual to be adopted by the MoH. Adoption of the PBF Manual satisfactory to the Bank by MoH would be a condition for disbursements on Component 1.

2. The development and testing of the PBF scheme is currently being financed by a separate preparation grant from the Health Results Innovation Trust Fund (HRITF). The testing of the PBF scheme in one district of Sogd oblast would continue through the first year of the project under this same grant. The expansion of the PBF scheme to the remaining seven project districts would start in the second year of the project, using Component 1 financing. The availability of functional facilities, basic medical equipment and trained staff are pre-requisites for implementation of the PBF scheme in the project districts. Therefore Component 2 activities would begin soon after effectiveness to ensure readiness of the PHC facilities.

3. The total funds allocated for the PBF component is USD12.8 million. These funds are envisaged to cover the performance-based payments to the PHC facilities as well as the costs for administration of the scheme (i.e. supervision, capacity building, first level verification and independent verification costs). The proposed division of funds for this component is as follows: (i) approximately 70 percent of the IDA & HRITF component funds would be allocated for performance-based payments to PBF service delivery units – each unit is defined as a RHC and its associated HHs, and would cover the income taxes on the incentive payments to PHC workers; and (ii) up to 30 percent of the IDA & HRITF component funds would be allocated for the costs of the first level verification and independent verification of the PBF scheme, costs of PBF implementation and capacity building for key stakeholders at the central, regional, and district levels, and strengthening of the HMIS to allow for the reporting and verification of the PBF indicators ; (iii) the Government contribution would cover the social security fund taxes that would be levied on the incentive payments to the PHC workers. To the extent practicable, the proceeds under the IDA funds will be disbursed on an equal basis as the proceeds under the Health Results Innovation Trust Fund Grant Funds.

4. The MoH's Coordination Group would enter into performance agreements with RHCs in project districts to deliver the agreed set of MCH and NCD health services subject to quality standards. A preliminary list of performance indicators is shown in Box 1 below. The final list of performance indicators would be defined in the PBF Manual. The agreements would also specify payment terms and conditions, including the outputs and quality indicators linked to payments, how payments would be verified and calculated and the frequency of these payments. Under the proposed contracting arrangement, RHCs would be responsible for their subsidiary HHs and would be responsible for entering into sub-contracts with the HHs. PHC facilities would be eligible for an advance to finance costs of initial inputs. The criteria for the allocation of the advance would be specified in the PBF manual.

5. The RHCs would be eligible to receive performance-based payments each quarter based on the verified: (i) Quantity of agreed MCH and NCD services delivered; and (ii) Quality of these services. The proposed formula for calculating PBF payments is illustrated in Box 2 below using a hypothetical example. The specific payment formula for the Project would be outlined in the PBF manual. The use of payments would be subject to simple spending rules designed to promote provider autonomy and accountability. Subject to these spending rules, PBF payments may be used for performance bonuses, to purchase minor inputs to deliver health services and/or for minor repairs. Payments would be released only after the first level of verification and specified sanctions would apply if fraud is uncovered during the independent verification. Simple rules would also be defined for the distribution of performance bonuses among staff in a PBF health facility.

Box 1: Preliminary Performance Indicators for the Tajikistan PBF Scheme

1. Number of children aged one year vaccinated with MMR.
2. Number of children under five weighed and provided with nutrition counseling and education at the clinic.
3. Number of nurse home visit nutrition counseling sessions (for health houses).
4. Number of women with first antenatal care visit within first 12 weeks of pregnancy
5. Number of pregnant women with at least four antenatal care visits.
6. Number of family planning visits by new and continuing users of modern contraceptive method (i.e. IUD, contraceptive pill, condom, Depo-Provera, implant).
7. Number of children with diarrhea treated with ORS.
8. Out Patient Visits among children under 5 years of age.
9. Out Patient Visits among population aged above 5 years of age.
10. Number of adults aged 40 and over with at least one blood pressure check.
11. Number of hypertensive adults with blood pressure recorded.
12. Number of hypertensive adults receiving correct anti-hypertensive treatment.
13. Quality checklist for structural quality: cleanliness, availability of supplies, basic drugs, staff on duty present at time of visit, good condition of infrastructure, working equipment, knowledge of staff on IMCI treatment.
14. Criterion Based Audits for clinical quality: verify if accurate treatment was provided for diarrhea, acute respiratory illness, and if IMCI protocols are followed (e.g. child sent for immunizations etc.)

Box 2: Hypothetical Example: PBF Payment for Facility Tajikistan

Consider that the package of services supported by PBF includes only immunizations, ante natal visits and institutional deliveries and that facility "*Tajikistan*" delivers 50 immunizations, 20 ANC visits and 10 institutional deliveries during the most recently completed quarter. Let us assume that it has been agreed that each immunization would be purchased at USD 0.10, each ANC visit at USD 0.20 and each delivery and USD 1. Further, let us assume that facility *Tajikistan* receives 60 out of a maximum of 100 points on the quality checklist used to measure quality during the first level verification visit and that the maximum quality bonus is USD 100.

Service	**Number provided**	**Rate (Unit purchasing price)**	**Total PBF Payment (USD)**
Immunization	50	0.10	5
ANC visits	20	0.20	4
Deliveries	10	1.0	10
Payment (Quantity)			***19***
Quality score received: 60/ 100			
Payment (Quality): 0.60 X 100			***60***
Total PBF Payment: Quantity + Quality			**60 + 19 = 79**

6. Two levels of verification would be implemented. The first level of verification would be carried out by District PBF Verification Teams. The State Health Activities Supervision Service (SHASS) will lead the verification efforts. The District PBF Verification Teams could possibly also include a representative from the rayon treasury department, staff from the central rayon hospital and other independent consultants as needed. The first level verification would be done on a quarterly basis prior to the release of performance-based payments and the independent verification after releasing payments. It is currently proposed that District PBF Verification Teams would be responsible for carrying out the first level verification of the PBF scheme in all participating PHC facilities. The MoH would issue a Ministerial Decree authorizing the SHASS to take responsibility for implementing the first level verification. The decree would also outline SHASS's scope of work, role and responsibility in the verification process, as well as the required deliverables, reporting system, and estimated costs for the activities. The rules and guidelines on the final composition of the District PBF Verification Teams would be specified in the PBF manual.

7. The independent verification of the PBF scheme should be done by an independent agency that has impeccable reputation and is well respected in Tajikistan and with the international donor community. Given its reach, credibility and technical expertise in maternal and child health care, it is proposed that UNICEF would be uniquely positioned to perform this role. The selection of UNICEF for this role was approved in accordance with the World Bank procurement procedures. The Ministry of Health and UNICEF would discuss and agree the Terms of Reference (TOR) for this assignment and would sign the standard form of agreement for the provision of such services by United Nations agencies under World Bank financed projects. It is proposed that the independent verification would be done once every six months in a sample of health facilities. The objective of the independent verification is to ensure that facilities report achieved results accurately, and to identify and penalize instances of falsified reporting and fraud. Other international and local agencies could also participate in the verification exercise as agreed with the Ministry of Health during the Project implementation. At a minimum, the independent verification would encompass the following aspects: (i) review of first level verification reports; (ii) home visits to a randomly selected sub-sample of PBF beneficiaries to verify receipt of services; (iii) checking facility records to assess concordance between reports of PBF performance and facility registers; (iv) verifying with staff that payments were received; and (v) verifying facility quality scores. Any instances of fraud identified would trigger sanctions which would vary depending on the severity of the fraud. Sanctions may be applicable to PBF health facilities and/ or to the District PBF Verification Teams if verification fraud is identified, and would be clearly spelt out in their contracts and terms of reference respectively. The agreement with the independent verification agency would include an obligation to transfer capacity to an independent local entity (to be identified during implementation) with the objective of ensuring in-country ability to carry out this function beyond the end of the Project.

8. An Oversight Committee would also be established with the responsibility to oversee the implementation of the PBF Component. The Committee would include representation from the MoH and the MoF. One of the main responsibilities of this Committee would be the review and approval of the findings and recommendations from the independent semi-annual verification. Some international development agencies active in the health sector could be invited as needed, to attend the independent verification review meetings.

9. The PBF scheme would be implemented in a phased manner in the project districts. At Project effectiveness, the scheme would be implemented in Spitamen district in Sogd region, during the first year of Project implementation. The PBF scheme would be implemented in all eight districts starting in the second year of Project implementation. The testing phase in Spitamen district would allow for fine-tuning the design and implementation arrangements to context of Tajikistan. A review would be conducted towards the end of the testing phase and lessons learned would be used to finalize the design

of the PBF and to guide the roll-out of the scheme across the remaining seven PBF districts in Khatlon and Sogd regions.

10. **Component 2: Primary Health Care Strengthening (USD6.0 Million)**. This component would aim to improve the capacity of Primary Health Care (PHC) providers to provide quality services.

11. *Sub-component 2.1 Quality Improvement (USD2.5 million):* The sub-component would finance the training of PHC doctors and nurses from the project districts and selected comparison districts in the 6 months Family Medicine training program. The Family Medicine training would be done in the Family Medicine training Centers in Sogd and Khatlon regions and in Dushanbe. Nurses and doctors from all PHC facilities in the project districts and selected comparison districts would also participate in continuous medical education (CME) on clinical treatment protocols for Maternal and Child Health (MCH) care and selected NCDs. The training would utilize recently updated and MoH approved modules developed by other development partners including GiZ, UNICEF, UNFPA, and WHO. The CME short courses would be done in the regional family medicine and district training centers. International and local technical assistance to support the introduction of a collaborative quality improvement process focusing on the management of three priority areas- preliminarily acute respiratory illness, child under-nutrition, and hypertension would also be supported under the project.

12. *Sub-component 2.2 Physical Infrastructure Improvements (USD3.5 million):* This subcomponent would support the improvement of PHC infrastructure in the project districts. This would include the provision of basic medical equipment and supplies to all PHC facilities in the project districts, and some rehabilitation and reconstruction works for selected PHC facilities to ensure basic functionality. Approximately twenty-four PHC facilities in the project districts have been identified for works according to agreed criteria (i.e. only rural health centers, size of population catchment area, reasonably sound, feasible building superstructure, facilities that are currently functional and confirmed to be on state owned land, and facilities following the Health Sector Master plan recommendations). The architectural designs for the facilities would start to be developed upon Project effectiveness, and the actual rehabilitation work would start in the second year of the Project.

13. **Component 3 Project Management, Coordination and Monitoring & Evaluation (USD4.20 million)**. The component would finance the expenses associated with the implementation and management of the project at the central, regional and district levels. Recurrent costs, office equipment and furniture, vehicles for project supervision, consultant salaries, travel expenses, study tours to enhance the knowledge on PBF schemes, and training for the Coordination Group (CG) members and project implementation staff at regional and district levels, monitoring and evaluation, and project audits would be supported.

Annex 3: Implementation Arrangements

TAJIKISTAN: Health Services Improvement Project

Project Institutional and Implementation Arrangements

1. The MoH is the main agency responsible for the preparation and implementation of the project. The Minister of Health has responsibility and oversight for overall project management to ensure that project resources are used as budgeted and that project development objectives would be achieved. The Coordination Group (CG) within MoH was established in November, 2012 to be responsible for project preparation and implementation. The CG is headed by the Minister and the First Deputy Minister is the Project Coordinator. The CG consists of 22 members who are technical experts and heads of department/units in MoH. The CG is supported by international and local consultants in technical, fiduciary and administrative functions.

2. The First Deputy Minister of Health, who is the Project Coordinator, would be responsible for daily coordination and oversight of project activities. The Coordinator is responsible for representing the MoH on any project activities that require contact and communications with the Government or Government agencies as well as the World Bank and any other agencies. In the absence of the Minister, the Coordinator is empowered to oversee project management and take decisions under the project. An Oversight Committee would also be established with a Ministerial decree, which will give it the responsibility to oversee and the implementation of the PBF Component. The Committee would include representation from the MoH, MoF, and other relevant stakeholders.

3. Various MoH heads of departments/units and staff would carry out relevant technical activities under the project, in addition to their routine work in MoH. Their specific responsibilities are being discussed and their TORs would be developed and included in the Project Operational Manual (POM). Local and international consultants will be recruited to assist the CG in project preparation and implementation. The CG is not an independent legal entity. Instead it is an integrated part of the MoH, unlike a traditional Project Implementation Unit (PIU) for the previous health sector projects funded by IDA. **Figure 1** below depicts the proposed organizational structure of the MoH CG that has the responsibility for implementing the Project.

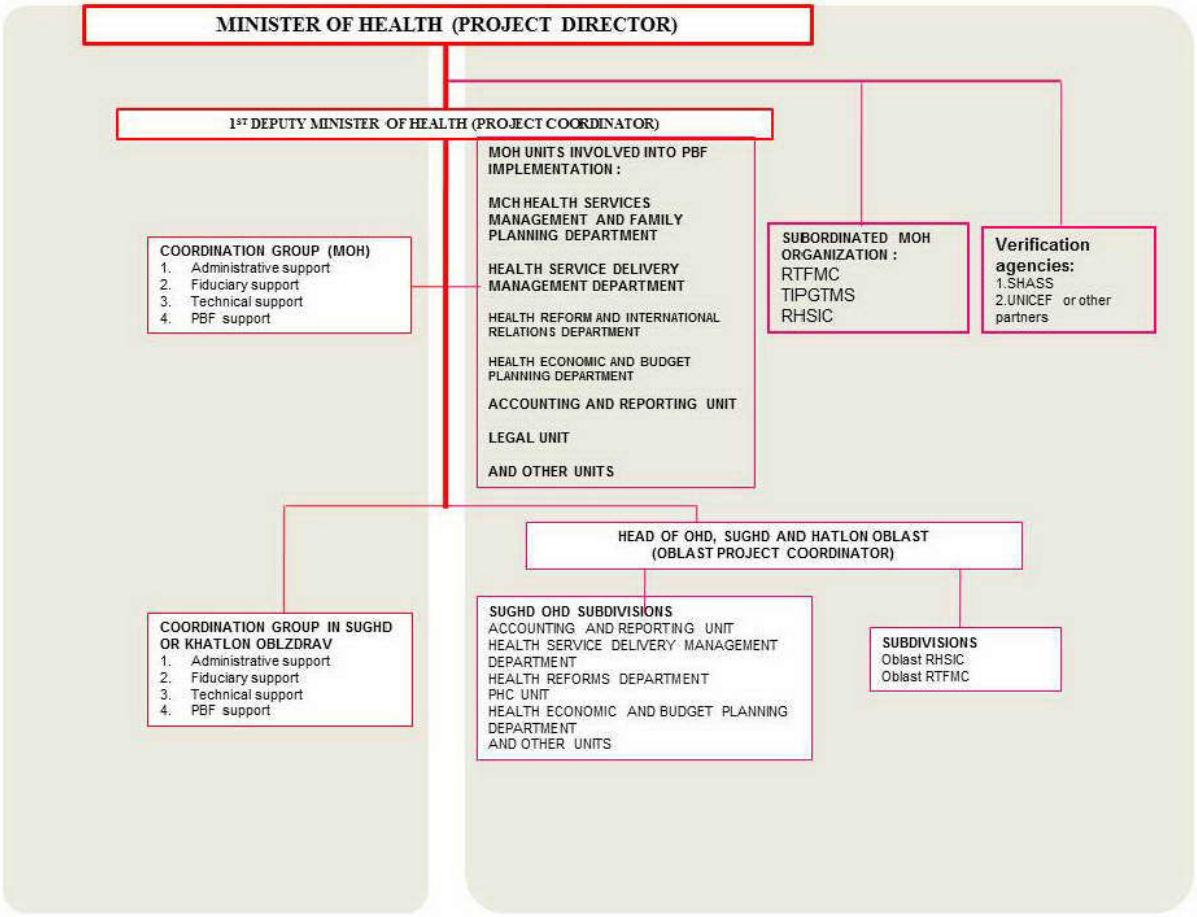
4. Project Monitoring & Evaluation (M&E) and Project Operations Manual (POM) – M&E would be managed by the M&E Technical Officer in the CG and at local levels. Detailed operation procedures would be developed and included in the POM. The draft POM would be ready by negotiations and would be adopted by the MoH to guide the implementation of the project, and would be updated periodically, as may be required, during project implementation. Adoption of the POM satisfactory to the Bank by MoH would be a condition for project effectiveness.

Financial Management, Disbursements and Procurement

Financial Management: The MoH would be responsible for overall implementation of the financial management (FM) function of the project including, monitoring the flow and accountability of funds to health care facilities participating in the project, budgeting, accounting, reporting, and auditing. The Treasury Department of the Ministry of Finance would ensure timely flow of funds once disbursed into the designated account to be maintained at a financial institution acceptable to the Bank. To this end the MoH accounting system is being improved significantly to cope with the rigorous requirement for project accounting and reporting; and staff capacity is being improved both in terms of numbers and skills. Improving the financial management capacity of the MoH entails installation of automated accounting system, with inbuilt controls and capacity to generate interim unaudited financial reports

(IFRs) and contracting of experienced financial management consultants to provide technical support to the accounting unit of the MoH, but not to take over the responsibility of project financial management and disbursement functions like in a stand-alone project implementation unit. Hardware and software for automation of the accounting system have been procured and installation and testing has been completed by end of May 2013. FM and Disbursement Consultants have also been hired to strengthen the FM capacity in the MOH.

Figure 1: Ministry of Health Project Implementation Structure



5. While the participating health care facilities would be responsible for accounts and records on the utilization of the funds received, the accounting system at the PHC will need to be improved to provide adequate accountability safeguards for the use of funds. The flow and accountability of funds to the pilot rural health facilities would need to be strengthened, given that the MoH will now have a role in approving the release of and proper accountability of the funds under Component 1. This would entail expanding the flow of funds and reporting schemes to include the MoH accounting and reporting unit. Improving accounting and reporting to include basic automation at the PHC through use of spreadsheets, and staff capacity development through training, would ensure improved integrity of the records maintained and reliability and timeliness of reports on utilization of the PBF funds during implementation.

Weaknesses and Action Plan

6. Overall, the financial management arrangements that are currently established by the MoH and PHCs are being improved. The MoH accounting system is manual, with accounting and reporting staff not familiar with the World Bank financial management requirements. As the MoH currently does not monitor budgeting and financing of PHC facilities that are financed from the local budget, the MoH would have difficulty monitoring the flow and accountability of the RBF funds. Although the MoH follows instructions on accounting and internal control issued by the MOF these are not adequate for effective project financial management. Additional project-specific instructions have been developed and included in the draft POM to be formally approved and adopted by the MoH, and implementation of these procedures monitored. The MoH accounting system does not have capacity to generate the interim financial reports; and integrity of the manual accounting system and reliability of the reports it generates cannot be ascertained. Accordingly automated accounting system with capacity to generate IFRs has been installed for the project.

7. Accounting and reporting at the PHC facilities is basic and manual, with staff not having adequate accounting skills or qualifications. Guidelines for the flow of funds and associated accountability mechanisms have not been developed; and the over-reliance on cash payments raises significant risk of funds not being used for intended purposes. The actions in the Table below are being implemented in order to strengthen the financial management arrangements for the Project by the specified dates.

	Action	**Responsibility**	**Due Date**
1	Develop Project Operational Manual (POM), incorporating Financial Procedures, with chapters on budgeting, accounting, internal control, financial reporting, funds flow, including flow and accountability of PBF funds, and audit. The POM to be approved and adopted by the MoH	MoH	**By Effectiveness**
2	Develop mechanism for the flow and accountability of PBF funds to PHC facilities, and adoption of the PBF Manual satisfactory to the Bank by MoH	MoH	**Disbursement Condition for Component 1**
3	Training of MoH accounting staff on project accounting and reporting and disbursement procedures	MoH	**During Implementation**

8. Successful implementation of the actions would ensure satisfactory financial management arrangements for the Project by effectiveness.

9. ***Planning and Budgeting:*** The Budgeting process follows the country's normal budgetary cycle, and is led by the Budget and Planning Department of the MoH, for the Central MoH and National Health facilities. The department, that is staffed by 7 people (currently only 6 positions are occupied), does not handle budgeting for the primary health care facilities at the local level as these are financed through the local authorities' budget. The MoH follows the 3-year Medium-Term Expenditure Framework (MTEF) budgeting format, based on new budget classification. The budget for the MoH and national health facilities is approved by the Minister prior to submission to the MoF for consolidation for the annual approval of the budget estimates by the Parliament. The budget for local health facilities is approved by the respective local authorities, in agreement with the financial department of the local authority or municipality. This is because local health facilities are directly subordinated to the local authorities. PHC facilities and hospital, as legal entities, are authorized to approve their own budgets. Overall there

are four categories of the budget: State Budget; Investment Budget; Capital Budget and Special Funds (Extra-Budgetary Funds). Execution of the budget is monitored through the quarterly reports on budget utilization (Form #2).

10. The key legal act of the budget legislation to design and regulate the PBF scheme is the Instructions "For recording and reporting on special funds by state budget institutions and organizations" # 16 of 03.02.2010 which authorizes managers of budget organizations to manage their special funds. PBF grant funds may be treated as possible type of special funds which may be owned by budget organizations (MOH), and spending these funds would be in compliance with the purposes determined by the Instruction on using special funds, approved by budget organizations and in compliance with economic budget classification[22] .

11. ***Flow of Funds:*** Release of funds to health facilities at the national level is based on Orders (*Prikaz*) issued by the Minister of Health. Release of funds to the local health facilities is not handled by the MoH, but is done directly through the Treasury System. The MoH makes all its payments through the Treasury System, with the Minister and Chief Accountant signing the relevant payment orders. Funds to the MoH (for Components 2 and 3) would follow the normal budgetary requests based on actual expenditure commitments and supported by approved *Smetas*, submitted by the MoH to the Treasury[23]. Funds for Component 1(PBF funds) would be transferred directly to the recipient health facilities, through instructions issued by the MoH to the Treasury based on performance agreements between the Coordination Group in the MoH and the PHC facilities to deliver the agreed package of health services. The health facilities would receive the performance incentives on a quarterly basis subject to meeting the criteria for determining health facility payments, including the verified volume of services delivered as well as the verified quality of these services. The PBF Manual would provide details of the performance agreement, the criteria to be met before incentive payments can be made, and the accountability mechanism for the PBF Component. Adoption of the PBF Manual satisfactory to the Bank by MoH would be a condition for disbursements on Component 1.

12. Grant funds would be deposited and maintained separately in foreign currency Designated Account opened in a financial institution acceptable to the Bank from where project funds would be transferred electronically to a Transit Account at the Treasury for immediate payments in local currency, based on approved *smetas*. Quarterly transfers to the PHC facilities would be based on reported quantity and quality of services by the facilities as checked and verified for accuracy during the first level verification, and in accordance with performance agreements between the Coordination Group in the MoH and the PHC facilities.

13. For Components 2 and 3, funds in Somoni would be transferred to the Central Treasury from the Designated Account (DA) for immediate payment requirements, based on expenditures already incurred or immediately to be incurred, as reflected in the expenditure requests prepared by the MoH Chief Accountant and approved by the Treasury. All payment orders would be approved by the Minister, or his designate, and the Chief Accountant after being verified by the FM consultants. The payment orders would be generated by the accounting system, signed by the FM consultants and certified by the Deputy Minister, and would have serial numbers for control purposes.

14. Payments in foreign currency would be made either from the Designated Accounts or directly from the Grant Account as Direct Payment depending on the threshold for such payments, as would be determined in the Disbursement Letter. Payment Orders from the Designated Accounts, prepared and signed by the FM consultant, would be approved by the Chief Accountant and the Minister. Withdrawal

[22] Instruction #16, Ch.5, art.19,p.4

[23] Approved *smetas* serve as evidence for budget organizations to spend special funds

applications for Direct Payments would be submitted directly to the MoF where they would be reviewed and forwarded to the person authorized to sign withdrawal applications on behalf of the Recipient.

15. In order to avoid the delays with payments from the Designated Account (as has been experienced with projects implemented by the Ministry of Education), the following funds withdrawal process is proposed:

- MoH would submit annual project budget in Tajik Somoni (converted from the project currency on the MoH approval date rate taken from MoF) to MoF and this estimate of expenditure would be approved and entered into the State Budget Execution System by MoF. MoH would have the option to re-submit the amended estimate of expenditure or the budget affected by the foreign exchange fluctuations of the project funds. MoF would convert project funds kept in the Designated Account whenever there would be such requests from MoH only.

- MoH would directly submit its requests on project funds conversions to the Treasury. The frequency of such requests cannot be limited by any circumstances. The Treasury would prepare a letter to the DA financial institution with the request to convert US Dollars kept in the Designated Account to the Tajik Somoni transit account of MoH kept in the Treasury.

- MoH would submit with disbursement requests all necessary supporting documents and estimate of expenditure, including bank transfer orders and cash withdrawal orders. The Treasury would process bank payments and release cash to the MoH, as may be appropriate for small payments, after all verifications conducted and approvals received

- Funds to the PHC facilities would be transferred directly to them, through the Treasury Agency bank, with copies of documents evidencing such transfers being sent to the MoH. The MoH would use such evidence of fund transfers to monitor fund utilization and accountability within the agreed reporting period.

This proposed flow of funds would take four banking days including final release of funds.

16. ***PBF Incentive Payments***. PBF incentive payments would be made based on the following scheme:

- Upon effectiveness of the Grant Agreement and upon fulfillment of the Disbursement Condition, based on Withdrawal Application for Advance into the designated account;

- Upon the request of the MoH the agreed financial institution would convert a certain amount into national currency and transfer it to the MoH special funds account, placing the funds in a separate PBF sub-account to distinguish it from other special funds of MoH;

- The MoH would submit the payment order to Central Treasury to transfer the PBF funds to the indicated PHC facility (Rural Health Centre);

- The Central Treasury would transfer money from the MoH PBF sub-account to a special PBF sub-account account in the Amonatbank of the relevant Rayon Finance Department (Local Treasury Office);

- Upon receipt of the payment order from the Local Treasury Office (LTO) the agency bank (Amonatbank) would make payment to the targeted employees of the eligible RHC's and its subordinated structures through the accounting office of the RHC, as it is a legal entity. Alternatively, the bank would transfer money to the personal accounts of each employee based on

the list approved by the RHC for that particular purpose. The target beneficiaries would also be identified in compliance with the list, approved by the district PBF verification committee, or any other authorized agency.

17. The FM Consultant would maintain a record to monitor the incentives payment cycle from the time the request of payment is received at the MoH to the time the funds are released by the Central Treasury. The FM Consultant would bring to the attention of the Project coordinator any inordinate delays, either within the MoH or at the Treasury.

18. ***Accounting Policies and Procedures:*** Local legislation on accounting encourages institutions to use manuals on internal budgetary and accounting policies and procedures issued in 2010. The law on accounting and the instructions of the Ministry of Finance (covering accounting, reporting, and budget formulation) are main reference documents for accountants in the MoH, subordinated health care agencies, PHC facilities and the Rayon/Oblast Finance Departments. Development of accounting policies and procedures for public sector is expected to be accomplished as part of the Public Sector Accounting Reform Project. In the meantime the MoH would need to develop a Financial Procedures Manual, as part of the POM, to cover the project financial management functions. The manual should, to the extent possible, be in compliance with procedures issued by the Ministry of Finance for donor-funded projects and would be ready in draft form by negotiations. As part of the POM the manual satisfactory to the Bank, would need to be adopted by the MoH and/or approved by the Minister prior to effectiveness. In addition, the Manual would need to be translated into Russian to make it easier for MoH accounting and reporting, budget and internal audit staff to use.

19. ***Accounting and Records:*** Accounting at the MoH is entirely manual; with computers being used mainly to process data in excel spreadsheet. Similar situation obtains in the PHC facilities and the Rayon (District) Finance Departments. The Rayon Finance Departments reports directly to the MOF and submits their reports, mainly budget execution reports, in flash drives, often with copies to the Oblast Finance Departments. The accounting system at the MoH and the primary health care facilities is largely manual with all transactions being processed manually. Financial reports are also prepared manually, a process that is laborious with the risk of errors and omissions not being detected. The head of accounting and reporting (or chief accountant) does not even have a computer, although other staff in the unit have computers and use excel spreadsheet for preparing reports. Hardware and software for the automation of the accounting system have been procured and installed; and testing of the accounting software is currently underway and is expected to be completed by June 30, 2013.

20. Most of the financial transactions at the RHC facilities relate to salary payments. Every month the Chief Doctor collects the payroll from the PHC Cashier and immediately submits the report upon payment of the salaries confirming the payments, usually within a day or two. Payment of salaries is made in cash and, unlike with pension payments, there is no use of plastic cards as ATMs are not readily available in many of the rural health facilities. Transactions at the RHCs are processed manually, or through basic computing using excel spreadsheet.

21. Accounts and records for the project would be maintained by the MoH, using the automated accounting system that has been installed for project accounting and reporting. The software has capacity to produce interim financial reports in accordance with formats agreed with the Bank. Books of accounts for the project would be maintained using the automated system that, in the medium term, would be integrated with the system to be established by the MoH. All transactions would be recorded on a cash basis of accounting (until appropriate accounting standards are adopted for the public sector), with supporting documentation maintained in files for ready access by auditors and during implementation support missions of the World Bank. The Chart of Accounts for the project would be based on the Chart

of Accounts developed by the MOF, and would be modified to allow tracking of project transactions and reporting by source of financing, project components, and type and category of expenditure.

22. ***Staffing:*** Accounting and reporting unit consists of 4 staff, including the head, who also acts as the chief accountant of the MoH. He also has some supervisory responsibilities over accounting and reporting staff of national level health facilities, but not of local health facilities. There are no accounting staff at the Rural Health Centers or Rural Health Houses, and very little record-keeping at that level. These facilities are supported by accounting and reporting staff of the PHC and Rayon Finance Departments. The head of accounting and reporting of the MoH would have overall responsibility for project financial management function. To ensure sound financial management of the project funds, a financial management consultant has been hired, and would be responsible for day-to-day financial management functions of the project. A disbursement specialist, also hired as a consultant, and would be responsible for project accounting and disbursement functions. The financial management and disbursement consultants would work under the direction of the Chief Accountant and would be expected to train other staff within the accounting and reporting unit. The MoH budget and accounting staff involved in the project implementation and the financial management/disbursement consultants have undergone specialized training on World Bank financial management and disbursement procedures during the Regional Fiduciary Learning event in May 2013. They are also being trained by the software vendor to be proficient in the use of the accounting software that has been installed by the MoH for the project.

23. ***Internal Controls and Internal Audit:*** The MoH has adequate ex-ante controls that ensure early detection of errors or fraud, but there is no systematic review of internal control procedures that would result into design of effective internal control system. Internal audit function is still weak, and focuses on regularity in individual transactions rather than on systemic issues and on effectiveness with which MoH resources are used. The EU has been working with the GoT to develop internal audit capacity through training and other capacity development measures. However, it was not clear whether the MoH internal audit unit has benefitted from the EU internal audit capacity development since the head of the unit was not even aware of the internal audit methodology that was developed as part of capacity building measures funded by the EU.

24. The MoH has documented in the draft POM, the internal control mechanisms to be followed in the application and use of funds and the implementation of the projects. The POM documents key internal control mechanisms to be followed by the MoH in the application and use of project funds, with specific focus on ensuring completeness of accounting transactions, reliability of accounting data, safeguarding of assets of the projects, flow and accountability of funds, including PBF funds, proper monitoring of contracts, proper authorization and documentation of all project expenditures, and full accountability for project funds. The POM reflects the typical organizational structure that allows for adequate segregation of functions, defined job descriptions with different authority levels, as well as the flow of funds to support project activities, including RBF funds flow to local health facilities, proper management of the bank accounts, including regular reconciliation of bank statements with project records. The payment order signing mandate will retain the current requirement of at least two signatures to make payments through the Treasury system.

25. The MoH is one of the pilot ministries for the introduction of internal audit function. An internal audit unit in the MoH was established in 2007 under Resolution of the Government # 603 which was followed by the Order of the of the Minister of Health #3 of January 4, 2008. The unit is only at the central level, and does not cover the local level health facilities level. Establishment of the internal audit unit in the MoH was done as part of the internal audit system development strategy developed with assistance from European Union (EU). The objective of internal audit function is to improve the

efficiency of the spending and improved control over spending. The auditors are required to advise the ministry on how control and efficiency of spending can be improved.

26. The internal audit unit currently has four people, the head, two chief specialists and one leading specialist. There is currently no internal audit manual/methodology, which means there is still no methodological basis for conducting internal audit. Instead the unit prepares annual work plans that are approved by the Minister of Health. However, full implementation of the plans is often not accomplished. For example, in 2011 the unit covered only 33 out of the 41 agencies that were to be audited. The unit also conducts ad hoc audits ordered by the Minister or heads of organizations in response to complaints. Audit findings and recommendations are submitted to the Minister of Health, with quarterly reports to the Agency for Financial Control and Anti-corruption. MoH would need technical support to develop internal audit manual/methodology, as well as internal audit charter to guide their activities. More training should be provided to the internal audit staff, especially in modern methods of internal audit as opposed to the compliance focused control function often confused with internal audit. Given the risks associated with the PBF component of the project regular reviews of the scheme by the internal audit unit would greatly contribute to risk mitigation measures.

27. ***Financial Reporting:*** The Accounting and Reporting Unit of the MoH produces a full set of financial statements, including a balance sheet and an actual versus budget report to Ministry of Finance. However, the MoH does not report on the entire health sector and does not prepare consolidated financial reports to monitor and analyze the whole health sector as rural health facilities are not subordinated to the MoH. Only the MoF receives both the MoH financial reports as well as the financial reports for the local health care facilities submitted by the District Finance Departments. The MoH does not appear to use the reports prepared for internal use, and the objective of the reporting at the MoH appears to be to meet external reporting requirements. These focus on budget execution, statistical needs, and tax information. Further, there is no evidence of recognizing and reporting accrued liabilities in the regular reporting, despite the possibility of unpaid liabilities by the MoH and the subordinated national health care agencies. Consolidating a report from the already available reporting forwarded to the Ministry of Finance, though not required, could assist the Ministry of MoH in the budgeting and planning processes, and also enable monitoring of the implementation of the reform in the sector.

28. For purposes of monitoring of project progress and financial performance Interim Un-audited Financial Reports (IFRs) would be prepared under the HSIP. The MoH would produce a full set of IFRs every calendar quarter throughout the life of the project. The format of IFRs would be agreed with the Bank prior to negotiations, and should include: (a) Project Sources and Uses of Funds, (b) Uses of Funds by Project Activity, (c) Project Balance Sheet, (d) Designated Account Statements, and (e) Statements of Expenditure (SOE) Withdrawal Schedule. These financial reports would be submitted to IDA within 45 days of the end of each quarter. The first quarterly IFRs would be submitted after the end of the first full quarter following the initial disbursement. The reporting requirements and IFRs formats have been incorporated in the FM part of the POM that would be approved/adopted prior to grant effectiveness.

29. ***External Audit*:** Similar to the majority of the public sector in Tajikistan, external scrutiny and audit of budget execution is weak, and the institution that has been carrying out external audit lacks independence and capacity to carry out audits in accordance with international standards. External audits in budget organizations have been conducted by the Agency for Financial Control and Combating Corruption, which focuses mainly on compliance with rules. The agency conducts bi-annual audits of the budget and submits audit findings only in summary format to the President and Parliament. There is no evidence that Parliament actually reviews the audit findings. There is also no evidence that the agency issues any recommendations that can be used to strengthen systems and procedures in the audited entity. With the recent establishment of the Accounts Chamber of the Republic of Tajikistan, as the supreme

audit institution, the quality and robustness of external audit are expected to improve once the Accounts Chamber builds necessary capacity in terms of staff numbers and skills.

30. Projects in the IDA portfolio in Tajikistan have been audited by eligible audit firms under a block audit arrangement, and the same would be adopted for the HSIP. In the past there were considerable delays with the submission of audit reports to the Bank. For example, audit reports for the fiscal year ended December 31, 2011 were received by the Bank in September 2012, a delay of three months. This delay was caused by the slow tendering process that was repeated every year as the audit contracts were signed for only one year. Going forward multi-year block audit contract arrangement has been adopted, and the audit reports for the fiscal year ended December 31, 2012 are expected to be submitted to the Bank by the due date of June 30, 2013.

31. The audit of HSIP would be conducted (i) on an annual basis; (ii) by independent auditors and on terms of reference acceptable to the World Bank; and (iii) according to the International Standards on Auditing (ISA) issued by the International Auditing and Assurance Standards Board of the International Federation of Accountants (IFAC). The terms of reference to be used for the project audit would be prepared by the MoH and cleared by the Bank, and submitted to the Committee for Investments before contracting the auditor, under the block audit arrangement.

32. The annual audited project financial statements would be provided to the World Bank within six months of the end of each fiscal year and also at the closing of the project. In accordance with the World Bank's Access to Information Policy audited project financial statements shall be made publicly available. Upon receipt of the audited financial management statements, the Bank would also make them publicly available. The cost of the audit would be financed from the proceeds of the Grants. The table below shows the audit reports that would be required to be submitted by the project implementation agency, and the due date for submission of the audit reports.

Audit Report	**Due Date**
Continuing Entity financial statements (MoH)	N/A
Project financial statements (PFS). The PFS include Project Balance Sheet, Sources and Uses of Funds, Uses of Funds by Project Activity, SOE Withdrawal Schedule, Designated Account Statement, and Notes to the financial statements, and Reconciliation Statement	Within six months of the end of each fiscal year and also at the closing of the Project

33. Given the significant investments in the PBF Component of the project it is recommended that a detailed operational audit of the PBF would be conducted once during the life of the project. Report of the operational review would be submitted to the MoF and MoH, and the findings and recommendations would be used by the MoF and MoH to improve fiduciary and management capacities related to payment of financial incentives to PHC facilities.

Disbursements

34. The project would use the traditional disbursement mechanism. Disbursements for all components would follow the transaction-based method, i.e., the traditional Bank procedures, including advances to the Designated Account, reimbursements with full documentation, Statement of Expenditure (SOE), direct payments and special commitments. Further details would be provided in the Disbursement Letter.

35. Applications would be prepared by the MoH and submitted on a quarterly basis or more frequently as necessary. Applications must be fully documented for: (i) contracts for goods and works greater than USD 100,000 equivalent; (ii) contracts for consultant services for firms greater than USD 100,000

equivalent, and for individuals greater than USD 50,000 equivalent. Statements of Expenditure (SOE) would be used for contracts below these limits and for incentive payments, training, and incremental operating costs. Documentation related to SOEs would be made available for the required audit as well as to Bank Implementation Support Missions, and would be retained by the MoH for at least one year after receipt by the Bank of the audit report for the last fiscal year in which the last disbursement was made. The minimum size of application for direct payment withdrawals and the issuance of special commitments from the Grant Account would be provided in the Disbursement Letter.

36. ***Designated Account***: Project funds would flow from: (a) the Bank, either: (i) via the DA to be maintained in a financial institution acceptable to the Bank, which would be replenished on the basis of SOEs or full documentation; or (ii) on the basis of direct payment withdrawal applications and/or special commitments, received from the MoH. Funds would be channeled to contractor, suppliers and consultants and incentive payments through the Treasury system. Withdrawal applications documenting funds utilized from the DA would be sent to the Bank at least every three months. The DA ceiling would be communicated in the Disbursement Letter that would also provide detailed instructions on withdrawal of grant proceeds from the Grant Account and the Designated Account.

Procurement

37. Procurement for the proposed project would be carried out in accordance with the World Bank's "Procurement of Goods, Works, and Non-Consulting Services under IBRD Loans and IDA Credits & Grants by World Bank Borrowers" (January 2011); Consulting services would be procured following the Bank's Guidelines "Selection and Employment of Consultants under IBRD Loans and IDA Credits & Grants by World Bank Borrowers" (January 2011); and the provisions stipulated in the Financing Agreement. The World Bank Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credit and Grants dated October 15, 2006 and revised on January 2011, would also apply. The general description of various items under different expenditure categories is provided below. For each contract to be financed by the Grant, the different procurement methods or consultant selection methods, the need for prequalification, estimated costs, prior review requirements, and time frame would be agreed between the Borrower and the Bank team and will be reflected in the Procurement Plan. The procurement for works and goods and non-consulting services would be conducted using the Bank's Standard Bidding Documents (SBD) for all ICB and an acceptable bidding document to the Bank would be used for all NCB. The standard NCB provisions for Tajikistan, as included in the Financing Agreement, would be applied to all the NCB contracts.

38. *Procurement of goods.* Goods to be procured under the project would include: basic medical equipment and supplies to PHC facilities, office equipment and furniture, and vehicles needed for the MoH CG. An inspection agent would be hired, for inspection of medical equipment.

39. *Procurement of Works.* Works to be procured under the project would include rehabilitation and/or reconstruction works for selected facilities in the project districts.

40. ***Selection of Consultants.*** Consultant services to be procured under this project would include: independent verification of the quantity of MCH and NCD services delivered, development of detailed designs for civil works, technical supervision, hiring of a third Party Quality Assurance/Quality Control consultant to ensure the quality of civil works. Individual consultants would also be hired to support project coordination and implementation. The following methods would be used for selecting consulting firms depending on the nature and complexity of assignments, interest to foreign firms and need for international expertise, estimated budget of the services: Quality and Cost-Based Selection (QCBS), Quality-Based Selection (QBS), Least Cost Selection (LCS), Selection Based on Consultant's Qualification (CQS), Selection under a Fixed Budget, Selection of UN Agencies following Para 3.15 of

Consultant Guidelines and Single-Source Selection (SSS). For the semi-annual Independent Verification of the PBF scheme, UNICEF will be hired following SSS using the form of agreement for the provision of such services acceptable to the Bank. Short lists of consultants for services estimated to cost less than USD100, 000 equivalent per contract may be composed entirely of national consultants in accordance with the provisions of paragraph 2.7 of the Consultant Guidelines.

41. ***Training.*** The project would finance training activities, including trainings for nurses and doctors from all PHC facilities in the project districts and selected comparison districts, training for the CG and personnel at the regional and district levels involved in administration and oversight of the PBF scheme. The MoH Coordination Group would develop a detailed training plan which will be agreed with the Bank.

42. ***Operational Costs.*** Operating costs that would be incurred by the MOH would include all expenses necessary to ensure proper implementation of the project, such as local travel and communication expenses, project monitoring and evaluation, etc. The budget for operating costs would be prepared and cleared with the Bank**.**

43. ***Assessment of the agency's capacity to implement procurement.*** The assessment of the MOH's capacity for implementation of procurement activities was carried out in February 2013 in line with the P-RAMS.

44. Procurement activities at the central level would be carried out by the MOH through the established CU. The CU would engage services of the experienced procurement consultant to ensure transfer of skills to the MOH procurement staff through on-the-job training. With a view of involvement of the MOH staff in procurement activities, a sustained training especially for staff working in the Procurement Department, Tender Evaluation Committee members and the MOH central and regional level management is recommended.

45. The overall project risk for procurement is rated ***'High'***. After mitigation measures are implemented, the residual risk would be '***Substantial***'. The risks associated with procurement and the mitigation measures were identified in the assessment of the agency's procurement capacity and are summarized in the table below:

Description of Risk	Risk Rating	Mitigation Measures	Residual Risk Rating
Government officials, who would be involved in project procurement through Tender Committees, may not be familiar with the international procurement procedures.	S	The CU would arrange for briefing of the evaluation committee members on the main principals of evaluation procedure before the evaluation starts.	M
Potential procurement delays due to relatively slow decision making process at the MOH and formalized internal procedures including involvement of SIC in procurement process	H	Monitoring procurement progress against the detailed procurement plan; timeframes for the decision, including the time allotted to make them, is covered in the Project Operation Manual.	S
Procurement of Civil Works: There is a certain scope of civil works. They are scattered across the eight project districts. The execution of scattered civil works could lead to quality issues in rehabilitation of the health facilities.	S	Hiring of third Party Quality Assurance/Quality Control consultant(s) to ensure quality of civil works; regular physical inspections by MOH Capital construction department engineers and Bank supervision mission.	M
Perceived level of corruption in the	H	Enforcement of public disclosure and	S

country is high.		transparency provisions of the Bank's Guidelines; Close Bank's implementation supervision.	
Average	H		S

46. ***Disclosure:*** The following documents shall be disclosed on the State Agency for Public Procurement /MoH website and in the notice board of MoH: (i) procurement plan and updates; (ii) invitation for bids for goods for all ICB and NCB contracts; (iii) request for expression of interest for selection/hiring of consulting services; (iv) contract awards of goods procured following ICB/NCB procedures; (v) list of contracts/purchase orders placed following shopping procedure on quarterly basis; (vi) short list of consultants; (vii) contract award of all consultancy services; (viii) list of contracts following DC or CQS or SSS on a quarterly basis; and (xi) action taken report on the complaints received on a quarterly basis.

47. The following details shall be sent to the Bank for publishing in the Bank's external website and UNDB: (a) invitation for bids for procurement of goods and works using ICB procedures, (b) request for expression of interest for consulting services with estimated cost more than USD300,000, (c) contract award details of all procurement of goods and works using ICB procedure, (d) contract award details of all consultancy services with estimated cost more than USD300,000, and (e) list of contracts/purchase orders placed following SSS or CQS or DC procedures on a quarterly basis.

48. ***Complaint Handling Mechanism:*** There is no independent complaint handling mechanism in the country. To deal with the procurement complaints received by the MoH, a complaint handling mechanism for the project would be developed and documented in the Procurement Manual for Health facilities and POM and will also be published in the MoH website/notice board. On receipt of complaints, immediate action would be initiated to acknowledge the complaint and redress in reasonable time frame. All complaints would be dealt at levels higher than that of the level at which the procurement process was undertaken.

Procurement Arrangements

49. All project procurement, including that associated with carrying out the verification activities of the State Health Activities Supervision Service, would be handled by the MoH Procurement Unit. Procurement within 30% percent portion of performance-based payments will be handled at the facility level following the Procurement Manual for health facilities. Most of such procurement activities would be below the shopping threshold.

50. ***Record keeping:*** The MoH and participating health facilities will maintain all procurement files and will make it available for procurement post review and audit purpose. The prior review contract details including payments made will be furnished to the Bank as part of IFRs.

51. ***Procurement Plan (PP):*** The total project financing is estimated at USD 23 million. Approximately USD12.8 million of the total financing would go towards the "performance-based financing scheme". About 70 percent of the Component 1 IDA and HRITF funds would be allocated for performance-based payments to eligible PBF service delivery units– each unit is defined as an RHC and its associated HHs; (ii) up to 30 percent of the IDA and HRITF funds would be allocated for the costs of the first level verification and independent verification of the PBF scheme; and (iii) the Government contribution (approximately USD2.0 million) would cover the majority of the income and social taxes that would be levied on the incentive payments to the PHC workers. The balance of total project funds would be used

for capacity building, monitoring and evaluation, rehabilitation/reconstruction of primary health facilities, additional medical equipment, and project management. The MoH would prepare a draft procurement plan for the first eighteen months of project implementation which provides the basis for the procurement methods and review by the Bank. This plan will be agreed between the Borrower and the Bank team by negotiations, and would be available in the project file. It would also be published on the MoH website (or notice board) and on the Bank's external website.

52. ***Procurement Manual for Health Facilities:*** The MoH would prepare a procurement manual for Health facilities as part of the POM for project implementation and to be agreed with the Bank by effectiveness. No amendment to the manual shall be carried out without review and clearance from the Bank. The MoH would deliver yearly procurement training on the manual to the procurement staff working at the facility level with assistance from the Bank.

53. ***Procurement Staff:*** The MoH procurement unit will have an additional procurement consultant under this project.

54. ***NCB Conditions:*** The NCB conditions would be part of the Financing Agreement.

55. ***Procurement Plan.*** The initial procurement plan shall be agreed between the Borrower and the Bank and be finalized at negotiations. After the Project is approved by the Board it would be published on the Bank's external website. The Procurement Plan would be updated in agreement with the Bank team annually or as required to reflect the actual project implementation needs and improvements in institutional capacity. The thresholds for methods of procurement and prior review limits are detailed below.

Expenditure Category	Contract Value (USD)	Procurement Method	Bank Prior Review
Goods	>200,000	ICB	All the ICB contracts
	≤ 200,000	NCB	First 2 NCB contracts
	≤ 100,000	Shopping	The 1st Shopping contract
	NA	DC	All DC contracts
Works (including non-consulting services)	>1,000,000	ICB	All the ICB contracts
	≤ 1,000,000	NCB	First 2 NCB contracts
	≤ 100,000	Shopping	The 1st Shopping contract
	NA	DC	All DC contracts
Consultant Services	Irrespective of Value	QCBS, QBS, FBS, LCS, CQS*	All contracts above USD 100,000 for firms plus the 1st CQS contract regardless of value; and all contracts above USD 50,000 for individuals; and all SSS contracts.
	NA	SSS	
	NA	IC	

Notes:

ICB – International Competitive Bidding
NCB – National Competitive Bidding
DC – Direct Contracting
QCBS – Quality and Cost Based Selection
QBS – Quality Based Selection
FBS – Fixed Budget Selection
LCS – Least Cost Selection
*CQS – Selection Based on Consultants' Qualification would be followed depending on type of assignments for estimated value less than USD 300,000
SSS – Single Source Selection
IC – Individual Consultant selection procedure
NA – Not Applicable

56. ***Frequency of Procurement Supervision.*** In addition to the prior review supervision to be carried out from the country office, the capacity assessment of the Implementing Agency has recommended two supervision missions per year during which ex-post reviews would be conducted on a sample basis (20 percent in terms of number of contracts) for the contracts that are not subject to the Bank's prior review. One post review report, which would include physical inspection of sample contracts, would be prepared each year. At least ten percent of the contracts would be physically inspected. Review on a sample basis of procurement at the facilities level will be conducted by external private auditors hired as a part of FM arrangements.

Environmental and Social (including safeguards)

Social (including safeguards)

57. ***Involuntary Resettlement.*** The project would carry out refurbishment and repairs of approximately twenty-four PHCs. Since most are minor repairs on existing sites and there is no new land acquisition, no involuntary resettlement impacts are envisaged and hence OP 4.12 is not triggered for this project. The 12 PHC sites screened for the EMP confirm that there are no involuntary resettlement impacts as defined by OP 4.12. In any case, prior to carrying out of any civil works, an environment and social screening would be done. In the event that any impacts related to land acquisition or restriction of access to services, assets or resources are seen, the PCU would immediately notify the World Bank and no civil works would proceed until appropriate mitigation instruments are prepared.

58. ***Focus on Women and Vulnerable Groups.*** Women, especially poorer rural women would be a major direct beneficiary group as much of the project is focused on improving maternal health services in the PHC facilities in underserved areas selected regions of the country. The improvements in infrastructure would also enhance the experience of visiting the PHCs for women due to availability of facilities like toilets, women wards etc. On the supply side, the focus on nurse training and post-graduate experience would also target women in the area of service delivery.

59. Children and infants are also a specific target group that would benefit directly from the Project. PDO indicators below show the strong focus on outcomes related to children's health. The focus on underserviced rural areas would directly target children from poorer families. Improved child health would have a direct positive impact on benefitting women who are the primary care givers, as well as school attendance rates.

60. The project M&E would disaggregate data to the extent feasible to capture the impacts on women and children as well as the elderly.

Environmental Safeguards

61. The Sub-component 2.2 *Physical Infrastructure Improvements* involves the re-construction and rehabilitation of physical infrastructure of Rural Health Centers, to upgrade them to basic levels of functionality to be able to provide satisfactory health services in accordance with the Project Development Objective. Twenty-four PHC facilities the Project districts have been identified based on agreed criteria and the facilities would be refurbished in two phases. While there is no foreseen expansion of the constructed area or substantial increase of capacity, the current situation of the facilities are quite degraded and would need significant rehabilitation and civil works to improve availability of basic utilities and services including water, sanitation and electricity.

62. The MoH has undertaken an assessment of sample facilities and has prepared an Environmental Management Framework (EMF) which defines critical mitigatory measures to be taken to address environmental impacts prior to and during construction phase. These include issues related to design, water supply, sanitation and sewerage, power supply and waste management including construction debris and asbestos. Worker safety during construction and occupational safety and healthcare waste management during facility operations are also addressed in the EMF. Site-specific Environment Management Plans will be prepared and approved prior to commencement of civil works at each site and EMP requirements will be included into bid contracts for civil works. In addition to regular monitoring and supervision requirements during and after construction, the EMF requires a third-party independent assessment to be carried out 8 months prior to the end of the Project life.

63. The MOH will hire a Construction Coordinator and an Environmental consultant who under the oversight of the Head of Construction Department in the MoH would be responsible for overall coordination and reporting to MOH and the Bank. They will be responsible for quality assurance of the site environmental control measures and their effectiveness and will have a right to suspend or amend construction works if there is an unforeseen risk or potential harm to the environment or if the EMP is not been implemented satisfactorily.

64. The EMPs will be prepared by the MoH and would be included in the civil works contracts for the construction of RHCs. The requirements of the site-specific EMP will be an integral part of the construction contracts. EMP requirements will be included into bid contracts for civil works. The contractor will not commence with dismantling and construction until the EMPs have been approved and cleared by the Supervision and Inspection Departments, Oblast Environment Departments and Rayon Environmental Services of the Environment Committee and also by the State Sanitary & Epidemiological Control Services of MoH. The MoH project team (Environmental Consultant and Construction Engineer) would prepare the EMP's and send to Bank for clearance. The EMPs must be cleared by the Bank, along with procurement contracts and design of civil works, before the start of construction. In addition to regular monitoring and supervision requirements during and after construction, the EMF requires a third-party independent assessment to be carried out 8 months prior to the end of the Project life.

65. Responsibility for the implementation of other aspects of the EMP will be the responsibility of the MOH. It will develop and approve healthcare waste management guidelines, hygiene standards, occupational and worker safety norms and requirements for protective equipment for healthcare workers. The training and capacity building of all healthcare workers will also be managed and supervision and monitoring of the regulatory sanitary-epidemiological safety related to healthcare service delivery. Each facility Head will designate a person responsible for the infection control, good practices in occupational safety and healthcare waste management. Responsibilities for staff training and overall implementation at each facility will be borne by the Chief Nurse.

66. The MOH will set up grievance mechanisms to ensure that communities can provide feedback or voice their concerns, if any. The neighboring community and local stakeholders will be consulted with regard to alternative location for continuation of RHC services during the time of construction and restoration. Site-specific EMPs must be consulted with relevant stakeholders in the Oblasts to discuss proposed facility design, scheduling of construction hours, habitat/ecosystem management and waste management.

Monitoring & Evaluation

67. The PDO and intermediate results indicators would be monitored using the following data sources: (i) routine data collection systems- PBF MIS; (ii) household and health facility surveys implemented as part of the IE in years 1 and 5; and (iii) Progress reports.

68. ***Routine data- PBF MIS***. Data collection and reporting for the Project would be harmonized with country systems. The PBF MIS, which is the data source for many indicators in the Results Framework (Annex 1), would be developed as a sub-module within the architecture of the new DHIS-2 based HMIS for Tajikistan. The primary source for the PBF MIS data would be: (i) service volumes data for PBF services; and (ii) quality data measured using a structured checklist during the first level verification. PBF data would be reported and verified quarterly. Since the PBF MIS would be web-based, any reporting updates to the database would be instantly visible to all authorized users in the system.

69. The MoH CG would have overall responsibility for M&E aspects of the project. An M&E Specialist in the MoH CG would be responsible for overseeing this function and generating progress reports based on routine data from the PBF MIS, household and health facility surveys, routine project activities and other relevant data sources.

Role of Partners

70. The project would be implemented in close collaboration with some development partners active in the health sector in Tajikistan. It is proposed that a credible independent organization such as the UNICEF office in Tajikistan would play a major role in the Project by leading the independent verification of the performance-based financing scheme. The selection of UNICEF for this role was approved in accordance with the World Bank procurement procedures. The Ministry of Health and UNICEF would discuss and agree the Terms of Reference (TOR) for this assignment and would sign the standard form of agreement for the provision of such services by United Nations agencies under World Bank financed projects. The technical assistance for the development of the independent verification methodology has been fully financed by UNICEF Tajikistan during the project preparation. UNICEF would also finance the initial training of the independent verification team. Other key international development partners such as WHO could also periodically participate in the independent verification process as agreed with the MoH. The Project would finance the operating costs for the semi-annual independent verification checks, while UNICEF would provide their technical staff and also cover some costs of their technical staff. UNICEF would also support the MoH in implementing an assessment tool to identify bottlenecks to the provision of quality services at the PHC level. Additionally, they would provide technical assistance and guidance on maternal and child health clinical guidelines and capacity building for PHC staff through their own budget as part of their regular contribution to the country program.

71. The EU financed HMIS project would work closely with the MoH and the Bank team in the customization of software modules to enable reporting of data from the PHC facilities to the central level, and the processing and tracking of payments at the central level. Efforts would be made to ensure

compatibility of the software modules with the new national DHIS-2 management information system for the health sector that is currently being tested in Tajikistan.

72. WHO would provide technical assistance and guidance on the development of NCD clinical guidelines and capacity building for PHC staff as well as participate in joint dialogue with Government and other stakeholders on the introduction of health sector reforms.

73. GiZ would provide technical assistance and support on maternal and child health clinical guidelines and capacity building for PHC staff. UNFPA would also provide technical assistance and support on family planning guidelines and capacity building for PHC staff.

Annex 4: Operational Risk Assessment Framework (ORAF)

TAJIKISTAN: Health Services Improvement Project
Stage: Negotiations

<table>
<tr><th colspan="7">Project Stakeholder Risks</th></tr>
<tr><td>Stakeholder Risk</td><td colspan="6">Rating: Moderate</td></tr>
<tr><td rowspan="2">1. Leadership Change. Future changes in the leadership in the Ministry of Health (MOH) and Ministry of Finance (MOF) could potentially affect the project if the new leadership does not support or understand the project's Results Based Financing (RBF) approach.</td><td colspan="6">Risk Management:
The establishment of the RBF Coordination Group in the Ministry of Health having the overall responsibility for the preparation and implementation of the project would ensure understanding and support of the Government to the project. Furthermore, a joint working group of officials from the Ministry of Health and Ministry of Finance would be established to ensure involvement of key technical officials of both ministries.</td></tr>
<tr><td>Resp: Client</td><td>Status: Not Yet Due</td><td>Stage: Preparation</td><td>Recurrent: ☐</td><td>Due Date: 30-Nov-2013</td><td>Frequency:</td></tr>
<tr><td rowspan="2">2. The Government counterpart contribution will cover a significant portion of the taxes on the PBF component, as well as salaries of Government officials and office space within the MOH and regional health departments. As this will be the first time to have Government co-financing to the Bank financed health projects, there is a risk of possible delays in counterpart funding.</td><td colspan="6">Risk Management
The Bank would work closely with the Government to agree on a schedule for payment of the counterpart contribution during the project negotiations, and this would be reflected in the project grant agreements. During implementation the Bank would also maintain continuous dialogue with the Ministry of Finance to ensure the necessary funds are set aside at the beginning of each year.</td></tr>
<tr><td>Resp: Bank</td><td>Status: Not Yet Due</td><td>Stage: Preparation & Implementation</td><td>Recurrent: ☐</td><td>Due Date: 29-May-2013</td><td>Frequency:</td></tr>
<tr><th colspan="7">Implementing Agency (IA) Risks (including Fiduciary Risks)</th></tr>
<tr><td>Capacity</td><td colspan="6">Rating: Substantial</td></tr>
<tr><td>Risk Description:
1. Limited experience in implementing</td><td colspan="6">Risk Management:
Project Management. To ensure adequate capacity in the MOH for project preparation and</td></tr>
</table>

RBF projects. The MOH has some experience in implementing externally financed projects. The execution of World Bank projects in the health sector has been satisfactory. However, RBF is a new way of providing development aid in Tajikistan, and not all levels of the health sector have a clear understanding of the intervention and its implications. 2. Monitoring and Evaluation. The RBF methodology would require an improvement of the existing Monitoring and Information System (MIS) as disbursements would be contingent on the accurate reporting of activities and results achieved by the facilities. 3. Procurement. The procurement capacity within the health sector is insufficient, and the risks could be significant.	implementation, an RBF Coordination Group has been established within the office of the Minister of Health. The Coordination Group with local and international technical specialists would work closely with various departments in the Ministry of Health and Ministry of Finance, as well as with the health authorities in the project participating rayons. Workshops on RBF will be organized at every level before the project becomes effective and would be ongoing during implementation. The project has allocated sufficient funds for training on RBF.

Resp: Client	Status: Completed	Stage: Preparation	Recurrent: ☐	Due Date: 31-Jul- 2014	Frequency:

Risk Management:

Monitoring & Evaluation. The team has evaluated the existing MIS and is working closely with the Bank ICT team and the EU funded HMIS project to identify mechanisms to ensure delivery of timely and reliable information on the project health results from the district to the central level. Additionally, an independent verification mechanism is agreed and UNICEF will play a leading role in developing the tools, providing training, and carry out the independent verifications under the project to verify the quality of the data reported by the Primary Health Care facilities as well as the findings of the first level verification.

Resp: Client	Status: Not Yet Due	Stage: Preparation and implementation	Recurrent: ☐	Due Date: 31-Dec-2014	Frequency:

Risk Management:

Procurement. To mitigate the risks, further procurement training would be provided for the implementing agency and the health facilities. An experienced local consultant is providing procurement support to the MOH in preparation of the project and would continue to do so during implementation. The MoH Procurement Unit would closely monitor the procurement implementation and coordinate with other departments within MoH. The MoH would prepare a detailed Project Operational Manual (POM) for project implementation including a chapter for simple procurement guidelines for the Health facilities. Hiring of a third Party Quality Assurance/Quality Control consultant will help to ensure the quality of civil works. The Bank's regional procurement team would provide advice and assistance on a regular basis.

4. Financial Management. The project would be implemented in a low FM capacity and weak fiduciary environment, using various elements of the country's Public Finance Management (PFM) systems which are still weak, making the performance based incentive scheme susceptible to fraud and misuse.	Resp: Bank	Status: In Progress	Stage: Implementation	Recurrent: ☐	Due Date: 31-Jan-2019	Frequency:
	Risk Management: Financial Management. Specific measures to mitigate fiduciary risks include capacity building interventions through consultant support and training, automation of the accounting and reporting system to strengthen controls, periodic review of accounting, reporting and internal controls by the internal audit unit, while the annual financial audit would be supplemented by an operational audit to be conducted prior to the Mid Term Review.					
	Resp: Bank	Status: In Progress	Stage: Implementation	Recurrent: ☐	Due Date: 31-Jan-2019	Frequency:
Governance	Rating	Substantial				
Risk Description: 1. The decision making process at the MOH is not always transparent and its oversight capacity is weak. Additionally, the responsibility for health service delivery is shared with local Oblast and Rayon health administrations, whose capacity for implementation is also relatively weak.	**Risk Management:** The project is planning to establish an Oversight Committee at the central level. The Committee will include leaders from MOH and MOF on the government side, and two to three development partner agencies, including UNICEF as an observer. Important decisions such as decisions on sanctions should be made by the Oversight Committee, and implementation of such decisions should be carried out accordingly by the MOH Coordination Group. Capacity building of the health and finance administrations at the central, regional and district levels to manage the performance based financing (PBF) scheme is an important activity financed by the project. International technical assistance on PBF would also be provided throughout the first two years of the project to help improve the design and implementation of the scheme.					
	Resp: Client	Status: Not Yet Due	Stage: Implementation	Recurrent: ☐	Due Date: 31-Jan-2019	Frequency:
Project Risks						
Design	Rating	Moderate				
Risk Description: 1. The use of PBF mechanisms that	**Risk Management:** Although emphasis would be on maternal & child health (MCH) services, the performance indicators will also include non-MCH services to prevent providers from ignoring other patients. The HMIS					

<table>
<tr><td rowspan="3">remunerate specific health results may produce undesired consequences that providers would only focus on the services incentivized.

2. PBF mechanisms require a Health Management Information System (HMIS) which is able to produce routinely information on health results. The current system produces some of the required information, but the quality of the information is not tested. Finally, project supervision of the PBF scheme which focuses on the verification of the health results would require additional financial resources and expertise, compared to traditional SIL projects.</td><td colspan="6">would also collect information both on incentivized and not-incentivized health services to detect and eventually correct the undesired consequences if providers would only focus on the services incentivized.</td></tr>
<tr><td>Resp: Client</td><td>Status: Not Yet Due</td><td>Stage: Implementation</td><td>Recurrent: ☐</td><td>Due Date: 30-Nov-2013</td><td>Frequency:</td></tr>
<tr><td colspan="6">Risk Management:

The Health Result Innovation Trust fund (HRITF) is providing additional resources for project preparation and supervision that would cover some costs for improving the HMIS and for more frequent supervision of activities under the PBF scheme. Additionally, the Bank and MOH are working closely with the EU financed HMIS project, to build RBF reporting modules into the open-source web based software that is being developed for Tajikistan.</td></tr>
<tr><td></td><td>Resp: Bank</td><td>Status: Not Yet Due</td><td>Stage: Implementation</td><td>Recurrent: ☐</td><td>Due Date: 30-Nov-2013</td><td>Frequency:</td></tr>
<tr><td>Social and Environmental</td><td>Rating</td><td colspan="5">Moderate</td></tr>
<tr><td rowspan="3">Risk Description:
1. The PBF intervention would be implemented on a pilot basis in 8 districts. Therefore, it is possible that Rayons not participating in the program could complain.

2. Environmental risks are rated as moderate, as the project will support the rehabilitation and reconstruction of approximately 24 Primary Health Care (PHC) facilities.</td><td colspan="6">Risk Management:

Project districts were selected on the basis of clear criteria which include average health outcomes and average health budgets. It is expected that the adoption of clear criteria for Rayons would mitigate the risk. Also it is proposed that the MoH have at least annual consultations with health administrators and providers from the non-pilot districts and regions to keep them informed of the program and ensure buy-in, in the event of future expansion or roll out of the program.</td></tr>
<tr><td>Resp: Client</td><td>Status: Not Yet Due</td><td>Stage: Implementation</td><td>Recurrent: ☐</td><td>Due Date: 30-Nov-2013</td><td>Frequency:</td></tr>
<tr><td colspan="6">Risk Management:

An Environmental Management Framework (EMF) has been prepared for the project. Prior to the start of civil works, individual site specific Environmental Management Plans (EMPs) would be prepared to guide the construction processes and ensure minimizing of negative environmental impacts. A construction coordinator at the central level and two construction engineers at the rayon level will be contracted to ensure the quality of the civil works and compliance with the EMPs. The head of the</td></tr>
</table>

<table>
<tr><td></td><td colspan="6">Construction Department in MOH will be responsible for the overall management and supervision of the construction coordinator and engineers.</td></tr>
<tr><td></td><td>Resp: Client</td><td>Status: In Progress</td><td>Stage: Implementation</td><td>Recurrent: ☐</td><td>Due Date: 01-Dec-2013</td><td>Frequency:</td></tr>
<tr><td>Program and Donor</td><td>Rating</td><td colspan="5">Substantial</td></tr>
<tr><td rowspan="4">Risk Description:
1. The project activities are largely financed by the Bank (IDA and HRITF) with no donor co-financing. There is Government in kind contribution of salaries of Government officials and office space within the MOH and regional health departments.

2. The PBF reporting mechanism will to the extent possible build on the new national HMIS supported by the EU, and currently being tested. There is a high risk that the testing phase and customization of the PBF modules could be delayed.</td><td colspan="6">Risk Management
N/A</td></tr>
<tr><td>Resp:</td><td>Status:</td><td>Stage:</td><td>Recurrent: ☐</td><td>Due Date:</td><td>Frequency:</td></tr>
<tr><td colspan="6">Risk Management:
The Bank team will work closely with the EU project and the MOH to ensure efforts are coordinated. The first year of the project would be dedicated to testing out the PBF mechanisms in only one of the project districts, which will allow some time to finalize the HMIS customization.</td></tr>
<tr><td>Resp: Bank</td><td>Status: Not Yet Due</td><td>Stage: Implementation</td><td>Recurrent: ☐</td><td>Due Date: 30-Oct-2013</td><td>Frequency:</td></tr>
<tr><td>Delivery Monitoring and Sustainability</td><td>Rating</td><td colspan="5">Substantial</td></tr>
<tr><td rowspan="3">Risk Description:

1. The resources of the PBF component would have to go through a number of verifications and processes before reaching the final beneficiaries. Therefore, there is the risk that delays in the transfer of funds could occur and reduce the positive effect of the PBF intervention.</td><td colspan="6">Risk Management:
Service standards would be established and included in the PBF manual to ensure timely first level verification and processing of PBF payments to the beneficiaries. The MoH accounting unit will maintain a monitoring record that would be included with the quarterly financial reports submitted to the Bank and to the Minister of Health. Any incidences of delays would be brought to the attention of the Minister of Health for appropriate interventions.</td></tr>
<tr><td>Resp: Bank</td><td>Status: In Progress</td><td>Stage: Preparation</td><td>Recurrent: ☐</td><td>Due Date: 30-Oct-2013</td><td>Frequency:</td></tr>
<tr><td colspan="6">Risk Management:</td></tr>
</table>

2. The World Bank fund (IDA and HRITF) are sufficient to finance RBF interventions in 8 rayons only to begin with. Therefore, the expansion and sustainability of the RBF intervention is an issue to be considered.	Even if the benefits of PBF interventions have been demonstrated in various countries, they represent a new mechanism to finance the delivery of health care in Tajikistan. The project comprises a strong Impact Evaluation component, financed by the HRITF, to generate evidence on the benefits of PBF interventions. It is expected that such evidence would produce support among stakeholders, including Government, population and development partners, toward the consolidation and expansion of the PBF interventions in Tajikistan.					
	Resp: Bank	Status: Not Yet Due	Stage: Implementation	Recurrent: ☐	Due Date: 31-Jan-2019	Frequency:
	Resp:	Status:	Stage:	Recurrent: ☐	Due Date:	Frequency:

Annex 5: Implementation Support Plan

TAJIKISTAN: Health Services Improvement Project

Strategy and Approach for Implementation Support

1. ***Implementation Strategy.*** The approach to implementation support to this project would include frequent implementation support visits to the country, especially in the first two years of the project during which the performance based financing pilot would be pre-tested and then launched. Frequent dialogue with the Government on progress in implementation of the project activities and reviews of the fiduciary and technical aspects of the project would facilitate continuous problem solving and help to mitigate any potential delays. During the first two years joint fiduciary and technical reviews would take place approximately once a quarter. Specific implementation support needs would be identified and agreed during these reviews. The first review would be to assess the readiness on the ground to test the PBF scheme in the first pilot district, and also to launch capacity building and civil works activities. In addition an international firm would continue to provide technical assistance to the Government on testing and refining the PBF scheme during the first year of the project, and possibly during the roll-out of the scheme in the second year of the project.

Fiduciary Support

2. ***Financial Management Supervision***. As part of its Project implementation support missions, the Bank will conduct risk-based financial management within ~~a~~ one year from ~~the~~ Project effectiveness, and then at appropriate intervals, depending on the level of assessed risk. During Project implementation, the Bank will supervise the Project's financial management arrangements in the following ways: (a) review the Project's quarterly IFRs as well as the Project's annual audited financial statements and auditor's management letters and any remedial actions recommended in the auditor's management letters; and (b) during the Bank's on-site missions, review the following key areas: (i) Project accounting and internal control systems; (ii) budgeting and financial planning arrangements; (iii) disbursement arrangements and financial flows, including counterpart funds, as applicable; (iv) internal controls and funds flow under the performance-based incentives financing sub-component; and (v) Governance and Corruption issues. Particular attention will be paid to the operation of the PBF scheme with missions to cover the MoH, the Treasury, and sample PHC facilities.

Procurement Supervision. In addition to the prior review supervision to be carried out from the country office, the capacity assessment of the Implementing Agency has recommended two supervision missions per year during which ex-post reviews would be conducted on a sample basis (20 percent in terms of number of contracts) for the contracts that are not subject to the Bank's prior review. One post review report, which would include physical inspection of sample contracts, would be prepared each year. At least ten percent of the contracts would be physically inspected.

Table 1. Implementation Timeline and Support

Time	*Focus*	*Skills Needed*	*Resource Estimate*
First twelve months	Technical Review: -Performance Based Financing Scheme -PHC Quality Improvement Mechanisms -Impact Evaluation	Health Specialist/Operations Specialist/Health Economist/HMIS Specialist/M&E Specialist Architect/Civil Engineer	

	Fiduciary Oversight -Financial Management -Procurement Safeguards Oversight -Environmental and social safeguards compliance	Principal Investigator/Researcher/Research Assistant Financial Management Specialist Procurement Specialist Environmental Safeguards Specialist	
12-48 months	Technical Review: -Performance Based Financing Scheme -PHC Quality Improvement Mechanisms -Impact Evaluation Fiduciary Oversight -Financial Management -Procurement Safeguards Oversight -Environmental and social safeguards compliance	Health Specialist/Operations Specialist/Health Economist/HMIS Specialist/M&E Specialist Architect/Civil Engineer Principal Investigator/Researcher/Research Assistant Financial Management Specialist Procurement Specialist Environmental Safeguards Specialist	

Table 2. Skills Mix Required

Skills Needed	***Number of Staff Weeks***	***Number of Trips***	***Comments***
Task Team Leader	12	4	Trips to be combined with other country project missions
Senior Economist/Co-TTL	10	4	Trips to be combined with other country project missions
Senior Operations Officer	7	4	Trips to be combined with other country project missions
Health Specialist	4	2	Trips to be combined with other country project missions
Operations Analyst	8	0	Based in country office
Senior Environmental Specialist	3	2	Based in Dehli CO
Procurement Analyst	5	0	Based in country office
Senior Financial Management Specialist	5	2	Trips to be combined with other country project

			missions
Financial Management Analyst	5	0	Based in country office

Table 3. Partners

Name	*Institution/Country*	*Role*
EU HMIS Project	European Commission Tajikistan	Support the customization of software modules to ensure compatibility with the DHIS-2 system to enable reporting of data from the PHC facilities to the central level, and the processing and tracking of payments at the central level.
GiZ		Provide technical assistance and support on maternal and child health clinical guidelines and capacity building for PHC staff.
UNFPA	UNFPA Tajikistan	Provide technical assistance and support on family planning guidelines and capacity building for PHC staff.
UNICEF	UNICEF Tajikistan	(i) Provision of technical assistance for the development of the independent verification methodology; (ii) Finance the initial training of the independent verification team; (iii) Lead the semi-annual independent verification of the performance based financing scheme; (iv) Provide technical assistance and guidance on maternal and child health clinical guidelines and capacity building for PHC staff.
WHO	WHO Tajikistan	(i) Provide technical assistance and guidance on NCD clinical guidelines and capacity building for PHC staff; (ii) Participate in joint dialogue with Government and other stakeholders on health sector reforms.

Annex 6: Impact Evaluation

Tajikistan: Health Services Improvement Project (HSIP)

1. This section describes the proposed design of the Impact Evaluation (IE) currently under consideration. The research questions and design were discussed and finalized at an Impact Evaluation consultative workshop held in Dushanbe in May 2013. However, the design may be modified, if needed, based on further consultation, technical peer review or lessons learned during the pilot of the PBF scheme, (to be implemented in Spitamen district during the first year of the project). The IE is financed through a separate Health Results Innovation Trust Fund (HRITF) Bank executed grant of USD1.5 million. Per the HRITF's requirements, a technical Concept Note on the IE that details its design and proposed methods and implementation will be prepared, and this CN will undergo technical peer review by technical experts in and external to the Bank.

Research Questions

2. The objective of the proposed Project's PBF IE is to build evidence on the impact and cost-effectiveness of PBF in Tajikistan. More specifically, the IE would seek to ascertain: (i) the impact and cost-effectiveness of the PBF model implemented in Tajikistan; and (ii) whether PBF is more effective or cost-effective if implemented in conjunction with additional low cost interventions that address potential constraints to PBF effectiveness.

3. The two interventions under consideration are: (a) Collaborative Quality Improvement, i.e., a facilitated quality improvement approach focused on common provider-identified objectives with performance feedback and competency training for provider Quality Improvement teams; and (b) Citizen Report Cards, i.e., providing local communities with information on the performance of their health facility by disseminating a facility report card that benchmarks the performance of their local facility against an appropriately chosen reference to the public with a view to informing potential service users for the facility. Two possible reference points for benchmarking include national standards for quality of care and the average quality of care in the country/ rayon/ survey sample. These performance/ benchmarking data would be obtained from surveys conducted for the IE and analyzed to develop facility report cards. The quality improvement intervention responds to policy concerns that performance incentives may not produce the desired improvements if providers lack the necessary competencies and knowledge. The citizen report card attempts to improve the effectiveness of PBF by strengthening the 'short route of accountability', i.e., by increasing accountability of health facilities to their local constituents.

4. Under the currently proposed evaluation design, clusters comprising of a Rural Health Center and their corresponding Health Houses in the seven project districts[24] would be randomized to one of three treatment groups:

- Treatment Group 1: PBF only
- Treatment Group 2: PBF plus Collaborative Quality Improvement
- Treatment Group 3: PBF plus Citizen Report Card

5. In addition, potential comparison districts that adjoin the project districts have been identified based on their similarity to the project districts. It is proposed that clusters comprising of a Rural Health Center

[24] The test rayon, Spitamen, would not be part of the Impact Evaluation sample.

and their corresponding Health Houses from these districts would be randomly assigned to the following arms:

- Treatment Group 4: Collaborative Quality Improvement only
- Treatment Group 5: Citizen Report Card only; and
- Comparison Group: Business-as-usual

6. The primary research questions for this impact evaluation are:

i. What are the effects of PBF on the coverage/ quality of targeted health services?
ii. What are the incremental effects of Collaborative Quality Improvement on the coverage/ quality of targeted health services, relative to PBF only?
iii. What are the incremental effects of Citizen Report Card on the coverage/ quality of targeted health services, relative to PBF only?
iv. What are the effects of Collaborative Quality Improvement on the coverage/ quality of targeted health services, relative to Business-as-usual?
v. What are the effects of Citizen Report Card on the coverage/ quality of targeted health services, relative to Business-as-usual?
vi. What is the relative cost-effectiveness of PBF only relative to: (i) PBF + Collaborative Quality Improvement; (ii) PBF + Citizen Report card; (iii) Collaborative Quality Improvement only; (iv) Citizen Report Card only; (v) Business-as-usual?

7. The Impact Evaluation may also measure health outcomes such as the hypertension prevalence and anthropometric measurements for children. However, it may not have sufficient power or, in the case of some outcomes, specific time to detect statistically significant effects on them.

Identification Strategy

Randomization

8. A randomized evaluation design would be used to answer primary research questions ii and iii and the relative cost-effectiveness of PBF vis-à-vis: (a) PBF + Continuous Quality Improvement & (b) PBF + Citizen Report Card. Successful randomization would ensure a balanced sample between treatment groups 1, 2 and 3 to facilitate causal inference. If the treatment groups are balanced at baseline, then differences at follow-up for key indicators in these two groups can be attributed to the interventions per se, rather than to some pre-existing difference between the two groups.

Difference-in-Differences

9. In addition, a difference-in-differences approach would be used to answer primary research questions i, iv, v and the relative cost-effectiveness vis-à-vis: (i) the business-as-usual, (ii) Citizen Report Card only, and (iii) Collaborative Quality Improvement groups. The difference-in-differences approach may be explained as follows:

$$\text{Difference-in-Differences (Impact)} = (Y_{t1} - Y_{t0}) - (Y_{c1} - Y_{c0})$$

Where:

Y_{t1} / Y_{c1} : Outcome in the Treatment / Comparison group at endline

Y_{t0} / Y_{c0} : Outcome in the Treatment / Comparison group at baseline

10. In order to estimate impact, the difference-in-differences approach compares the change over time in the treatment groups to that in the comparison group. This accounts for baseline differences among the groups and changes over time that are common to the groups thus enabling a valid estimate of impact. To further increase internal validity of the difference-in-differences design, data from a health facility survey completed in 2012 and administrative data would be used to match individual health facilities in treatment groups 1, 2 and 3 to those in treatment groups 4 and 5 and comparison group 1 on baseline (pre-intervention) characteristics. The following matching variables may be used:

- Staffing
- Infrastructure
- Functioning equipment
- Drug availability
- Range of services delivered
- Catchment area population
- Outpatient visit volumes

11. Preliminary power analysis indicates that the evaluation will be statistically powered to detect an increase of 5 to 6 percentage points in an index of quality of care measures, and, an increase of 10 percentage points in utilization of services under specific assumptions. However, these analyses are based on assumptions as limited quantitative data is available to conduct more precise power calculations at this stage, and may need to be adjusted at a later stage. The IE methods will undergo a rigorous technical peer review per the requirements of the Health Results Innovations Trust Fund

Data

12. Outcomes in treatment and comparison groups would be measured over time using a combination of household survey and health facility survey data. In addition, PBF and other administrative data would be used to track outcomes over time in the two treatment groups.

13. There would be a ***baseline survey*** before the start of the second year of the project, i.e., before scaling up interventions from Spitamen to the remaining seven project districts that are part of the IE sample. The evaluation team would finalize the required baseline data collection instruments after considering budget and the availability of existing data.

14. A ***follow-up survey*** would also be administered approximately **42 months** following the start of the PBF scheme in the remaining seven treatment districts. Budget and other constraints permitting, a follow-up survey would also be implemented approximately 24 months following the start of the second year of the project. The results of the impact evaluation would inform the Government of Tajikistan on possible scale up of the PBF program or its components to more districts.

Administrative Data

15. In addition to primary survey data, the evaluation would leverage administrative data on PBF targeted services to supplement the analysis in treatment groups 1 and 2. This includes administrative data collected through the upgraded HMIS District Health Information System 2 (DHIS 2) which would also be the information systems backbone for administering PBF.

Survey-based data collection instruments

16. Health facility-based and household survey instruments would be implemented in a sample of facilities, health workers and households in the three study groups. The survey instruments would draw on existing instruments that have been validated in other contexts including those in the HRITF IE toolkit.

17. ***Facility assessment.*** One facility assessment instrument would be completed for each facility included in the survey sample. The facility assessment would seek to collect data on structural aspects of quality and service delivery including staffing, equipment, infrastructure, drugs and supplies, record keeping and service volumes.

18. ***Health worker interviews***. At each sampled health facility, health workers delivering adult and maternal and child health (MCH), nutrition and Non Communicable Disease (NCD) services would be interviewed. In addition to collecting data on health worker characteristics and motivation, the interview would include provider vignettes on MCH and nutrition protocols and diagnosis, as well as non-MCH services (such as NCDs) to assess health worker knowledge. The sample of interviewees would also include the facility manager or in-charge. At mid-term and end-line, the health worker interviews would seek to capture information on organizational and other changes related to PBF implementation at the facility level.

19. ***Patient interviews***. The study includes exit interviews with patients receiving MCH and nutrition and NCD services. The exit interview would cover recall of visit activities and perceived quality of care.

20. ***Direct Observation.*** The study would include direct observations of service delivery by health workers for specific MCH and nutrition services (such as visits for children under 5, prenatal care, and growth monitoring/ nutrition) and NCD services (hypertension/ high blood pressure identification and management).

21. ***Household survey***. The household survey would include a sample of households in the project districts. The household survey would collect data on households characteristics, household health expenditures, care seeking and health service utilization, particularly for MCH and nutrition and NCD services and on nutrition practices for children under age five. Depending on time and budget constraints, the household survey may include food diaries or food frequency questionnaires in a sub-sample of the household survey households that include a child under age five. In addition, constraints permitting, the household survey might include anthropometric measurements like weight and height for children, and weight, height and blood pressure measurements for adults.

Qualitative Research Component

22. The project and IE teams recognize the importance of complementing the quantitative data collection with more in-depth qualitative research. This would include focus group and semi-structured interviews at baseline, mid-line and end-line to respond to different research questions regarding PBF implementation and responses at the national, district administration, health provider and household levels. The research questions for each point in the project cycle would be finalized in discussion with the Government and stakeholders involved in PBF in Tajikistan.

Process monitoring

23. A process monitoring component would also be incorporated into the IE design. The objective of the process monitoring component would be to: (i) Monitor whether the interventions are being

implemented as intended to inform IE analyses; and (ii) Monitor implementation to inform HSIP project management and correct implementation as necessary. Process monitoring would cover both the testing of the PBF scheme in Spitamen and as well as implementation during the expansion to the remaining seven districts.

24. Data for the process monitoring would be obtained by analyzing administrative data and qualitative primary data collection in a purposively selected – and restricted – sample of health facilities.

Annex 7: Economic and Fiscal Analyses

Tajikistan: Health Services Improvement Project

1. The economic and fiscal analyses carried out during the preparation of the project covered: (i) the estimation of the project's development impact; (ii) the rationale for public involvement; (iii) the World Bank's contribution to the project; (iv) the feasibility of cost-effectiveness analysis of the PBF interventions; and (v) the fiscal impact and sustainability of the project.

Project's development impact

Economic rationale for using PBF approach

2. The institutional and financial arrangements in the Tajik health sector are characterized by separation between the regulatory, financing and provision functions. The MoH formulates health policy and is responsible for controlling the quality, safety and effectiveness of health services, pharmaceuticals and medical equipment. PHC facilities (i.e. rayon and city policlinics, rural health centers and health houses) are supervised by the respective executive local authorities (hukumats) of cities and rayons. PHC facilities are financed through local Governments and the main method to allocate public resources is based on line-item budgets. Therefore, financial resources are allocated on the base of the installed capacity (e.g. number of hospital beds, health staff) with scarce consideration of population health needs. This approach perpetuates some of the inefficiency of the Soviet health system as provider organizations tend to devote their energy to securing funds rather than to improving efficiency or the quality of care.

3. The split between functions introduces a principal-agent problem in the health sector.[25] The problems arise because a *principal* (i.e. MoH and local authorities) delegates the provision of health service to an *agent* (i.e. health care provider) in an environment characterized by (i) *moral hazard*: the agent's action (e.g. effort, quality) affects the principal payoff, but the action is not directly observable by the principal; (ii) *information asymmetry / adverse selection*: the agent has some private information, for example is better placed to judge the severity of the condition of the patient treated; and (iii) *costly outcome verification*: the agent can observe some outcomes, such as the quality of care delivered better than the principal. The consequences of the principal-agent problem in the health sector are well known: the agent would act for his or her own interests rather than in the best interests of principal. The difference between the principal's welfare when there is full information or coincidence of objectives and when there is not is, is known as the agency cost.

4. Economists have examined two ways of mitigating agency costs: implementation of incentives and enhancement of information. The first type of solution is for the principal to put in place a set of incentives which encourage the agent to carry out actions in accordance with the principal's requirements. To align the interests of the agent with those of the principal the compensation package should include incentives that satisfy: (i) *the participation constraint*: the health provider is better off in participating in the contract; and (ii) *the incentive compatibility constraint*: the agent is better off if she acts as desired by the principal.

5. Therefore, a PBF scheme can solve the principal-agent problem by devising a remuneration schemes that explicitly link payment with the achievement of output targets, thereby enhancing productivity and foster entrepreneurial behaviors. The proposed project introduces a PBF contract between the MoH and

1. See: Prendergast (1999) The Provision of Incentives in Firms JEL 37(1); Dixit (2002) Incentives and Organizations in the Public Sector: an Interpretative Review, JHR 37(4); Savedoff (2010) Basic Economics of Results-Based Financing in Health, WB.

PHC facilities that provides incentives to the agent to perform in the way the principal would like to because it would be in the agent's best interest to do so. The scheme proposed herewith established indicators of performance that make clear what principals want and that give agents financial incentives for achieving defined performance targets. Also, by linking allocation of financial resources to achievement of pre-defined performance targets as well as implementation of quality improvement plans, the PBF scheme would align the incentives of providers and purchasers of healthcare services, thereby improving health system efficiency.

6. Moreover, the improved monitoring and evaluation of health providers' performance, introduced by the project represents a complementary strategy to mitigate the problem of information asymmetry. The *principal* would have more objective information and data on the achievements and shortcomings of the *agents*, therefore the information asymmetry and the related agency costs would be reduced.

Cost-benefit analysis

7. The economic analysis is based on of the following assumptions:

- **Population Covered:** The proposed project would be implemented in eight rayons covering about 1.86 million people, representing around 25 percent of the entire population. Population growth up to the year 2030 is based on UN population projections (medium variant) for Tajikistan as a whole.[26]

- **Discount Rates:** Financial costs (project costs and efficiency savings) are discounted at a basic rate of 7 percent, to account for future inflation[27]. A lower range of 5 percent is also applied. Lower discount rates mean that the present value of future costs and benefits would be greater. The future stream of annual DALYs saved (that is, benefits) is discounted at 3 percent (with an upper sensitivity analyses of 5 percent), per guidelines from WHO and the Disease Control Priorities (DCP-2) project.[28]

- **Benefits:** The direct and indirect benefits associated with the Project's interventions economic are summarized in Table 1 below:

Table 1. Casual chain: Project components and sub-components, interventions, intermediate results and final results

Components and Sub-components	Interventions	Intermediate results	Final results
1: Performance- based financing	Payments to rural health centers and health houses upon verification of quantity and quality of MCH and NCD services delivered	Increased access to rural PHC health services and improved quality of MCH and NCD services	Improved MCH and NCD health outcomes
2.1: PHC strengthening – quality improvement	Training of doctors and nurses at PHC facilities	Improved prevention and management of health conditions at PHC level	Improved MCH and NCD health outcomes
2.2: PHC strengthening- physical infrastructure	Equipment and rehabilitation of rural health centers and health houses	Increased access to rural PHC services	Improved MCH and NCD health outcomes

[26] Source: http://www.un.org/esa/population/.
[27] Source: IMF. World Economic Outlook, October 2012.
http://www.imf.org/external/pubs/ft/weo/2012/02/weodata/index.aspx
[28] See: http://www.dcp2.org/.

improvements			
3: Project management	Operational cost of the MoH CG	Project executed	Results obtained in timely, efficient and transparent manner

- **Reduction in DALYs:** DALYs, which represent the sum of years of potential life lost due to premature mortality and the years of productive life lost due to disability, have a built-in age-weighting and discount rate of 3 percent. DALY reduction in each major disease category has been estimated for each intervention. Specifically, a 3 percent DALY reduction of communicable, maternal, perinatal and nutritional conditions is linked with the project goals of introducing performance based financing. The reduction in DALYs from PHC strengthening (physical infrastructure improvements and improved training) is conservatively set at 0.3 percent across all diseases. These reductions in diseases from the interventions of the project (better facilities, better training, and increased access to access to MCH and NCD services) took the conservative values for interventions from the DCP-2.

- **Counterfactual Scenario for DALYs:** The baseline DALYs for 2014 were calculated for the various conditions from WHO estimates for the Eastern and Central Asia region, adjusted for the population size of the project (1.86 million people) and the age structure of Tajikistan (from the UN Population Division) for the years 2014, 2018, and 2030. These include the forward projections of DALYs averted (that is, healthy life years gained) from 2014 to 2030. The baseline value used the WHO mortality rates for 2015, adjusted for age structure of Tajikistan for 2014.

- **Valuation of DALYs** used a very simple rule. Each DALY saved is valued at per capita income (using a starting value of about USD912 for 2012). An upper, but still conservative, estimate values each year of life as three times per capita income, as per the DCP-2 and Copenhagen Consensus guidelines.[29] Studies of valuation of life in the United States utilize a much higher values of year of life that would produce more extreme results.

- **GDP Growth:** An annual growth rate of 7 percent in real per capita GDP is used based on the estimates provided by the IMF.[30]

- **Project Investment and Recurrent Costs:** The total financing of this Project is USD19.8 million in nominal terms, which would be disbursed over a period of four years and half (January 1, 2014 – June 30, 2018). Given cross benefits across project components (see below), the entire project costs (and not simply the components that are expected to yield measurable benefits) are used in the cost-benefit analyses. The recurrent costs are estimated at 10 percent per year of the investments in equipment and rehabilitation work (about USD3.3 million in nominal terms), even though the project would mostly reequip and rehabilitate existing PHC facilities.

Aggregated and Marginal Benefits of the Interventions: In this project, interventions are integrated. For example, health benefits deriving from the adoption of PBF under component 1 could be coupled by the increased coverage of PHC services deriving from the investment under subcomponent 2.2 and the better-quality care deriving from the training provided under

[29] See: D. Jamison, P. Jha, and D. Bloom, "Copenhagen Consensus 2008 Challenge Paper: Diseases," 2008; http://www.givewell.org/files/DWDA%202009/Stop%20TB/Copenhagen%20Consensus%20Paper-Diseases.pdf.
[30] IMF. World Economic Outlook, October 2012

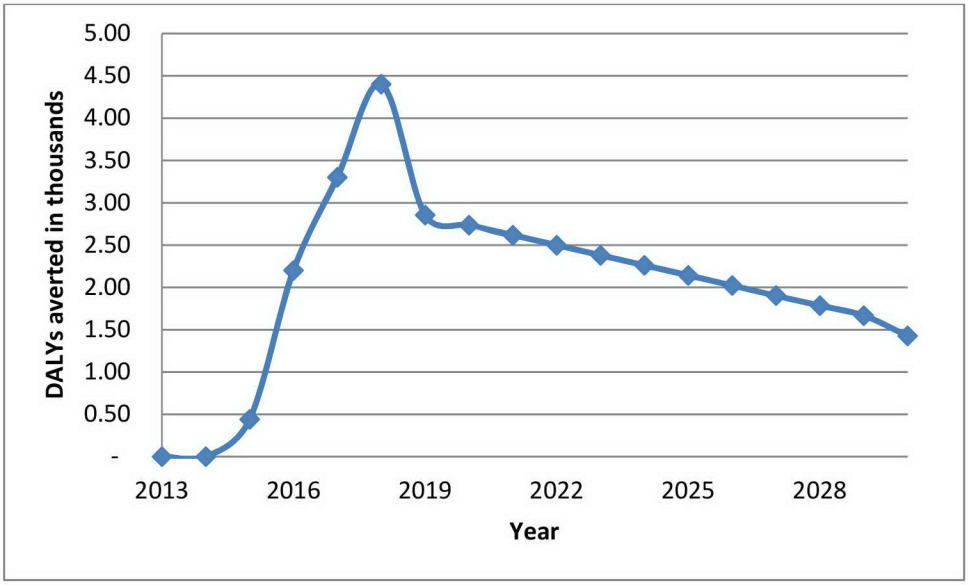
subcomponent 2.1. Thus, caution is required in interpreting the incremental health gains (DALYs saved) derived by each subcomponent.

8. Figure 3; show the total DALYs averted in 2018. Consistent with the epidemiological profile for Tajikistan and the project focus on MCH, DALYs averted are from both communicable diseases, maternal, perinatal and nutritional conditions and reduced NCD burden. Indeed, about 34 percent of the reduced DALYs arise from reduced cardiovascular disease.

Table 2. Total DALYs (in '000s) averted by 2018, baseline scenario

Cause/Year	2018	% of total	2030	% of total	Cumulative
All causes	4.40		1.43		36.63
Communicable, maternal, perinatal and nutritional conditions	2.11	48%	0.27	19%	
NCDs	2.29	52%	1.16	81%	
Cardiovascular disease	1.51	34%	0.31	22%	

Figure 3. Total DALYS averted by year compared to Europe and Central Asia counterfactual projections, baseline scenario



9. The overall results of the economic analyses, baseline scenario, are presented in Table 3. In the baseline scenario each DALY saved is valued at per capita income, costs are discounted using a 7 percent inflation rate and DALYs are discounted at 3 percent discount rate. The estimated internal rate of return (IRR) for the baseline scenario is 17.1 percent, which exceeds the 11 percent discount rate. In other words, the difference between the IRR and the discount rate ensures that the health interventions proposed by the Project are economically profitable

Table 3. Project costs, benefits and IRR, baseline scenario

Year	Direct/Indirect Benefits in '000s USD (2014 terms)	Investment Costs in '000s USD (2014 terms)	Net Benefits in '000s USD
2013	-	-	-
2014	-	3,100	(3,100)
2015	458	4,299	(4,142)
2016	2,385	4,891	(3,215)
2017	3,732	2,939	132
2018	5,134	2,212	2,234
2019	3,444	250	3,094
2020	3,415	233	3,065
2021	3,380	218	3,030
2022	3,338	204	2,988
2023	3,289	190	2,939
2024	3,233	178	2,883
2025	3,169	166	2,819
2026	3,096	155	2,746
2027	3,015	145	2,665
2028	2,925	136	2,575
2029	2,824	127	2,474
2030	2,505	119	2,155
Total	**49,341**	**19,562**	**25,341**
	Net Present Value (in '000s)		$7,559
	IRR		17.1%

Table 4. Sensitivity analysis of results (in USD)

	Total costs	Total benefits		Net benefits	
		1 DALY = 1 times GDP per capita	1 DALY = 3 times GDP per capita	1 DALY = 1 times GDP per capita	1 DALY = 3 times GDP per capita
Baseline scenario: deflator rate of 7% and DALY discount rate of 5%					
Values (in 000s)	$19,562	$49,341	$148,023	$29,779	$128,460
NPV (in 000s)				$7,559	$54,615
IRR				17.1%	72.2%
Alternative Scenario: deflator of 5% and DALY discount of 5%					
Values (in 000s)	$20,608	$42,004	$126,013	$21,396	$105,404
NPV (in 000s)				$7,030	$56,693
IRR				13.6%	67.2%

10. Table 4 presents the sensitivity analysis of the results of the cost-benefit calculation obtained changing some of the key assumptions. The net present value (NPV) and IRR were quite sensitive to the value of a DALY. If a DALY is valued 3 times per capita GDP the NPV raises more than seven times and the IRR increases up to 72 percent. In contrast, the IRR was not very sensitive to changes in the

discount rates for DALYs and to the deflator (inflation) rate. For example, alternative scenario (deflator of 5% and DALY discount of 5%) shows an IRR of 13.6 percent.

The rational for public involvement

11. In Tajikistan right to health care is a constitutional right that should be ensured through free provision of medical services in public institutions[31]. The Tajik Government has aimed to promote the development of a private health sector. The Law on Private Medical Practice was adopted in 2002 and a licensing committee was established under the MoH for the opening of private health facilities. The development of private health care services providers has been confined to pharmacies and dentists. Private outpatient and hospital facilities have been opened only in Dushanbe and the other main cities.

12. Many factors have delayed the development of private practice in rural Tajikistan. Most importantly, the vast majority of the rural population has very limited resources available for medical services. The investment in private health facilities is therefore economically not viable as there are very limited incentives for doctors to open private practices. Therefore, the alternative of relying on private health services providers is not currently feasible in rural Tajikistan.

The World Bank's contribution to the project

13. The rationale for World Bank's involvement in the proposed project is two-fold. First, Bank's long-term engagement in the health sector trough the Primary Health Care Project and the Community and Basic Health Project generated a deep knowledge of the sector and its development challenges that informed the preparation the proposed operation. Second, the presence at the Bank of the Health Results Innovation Trust Fund (HRITF) that has the objective of supporting result-based financing (RBF) programs in low-income countries. Thanks to the generous support provided by the HRITF, the World Bank has been able to: (i) bring in the preparation of the proposed operation global expertise and best practices in the design and implementation of RBF solutions in the health sector; (ii) provide technical assistance and a recipient executed grant to support project preparation; and (iii) leverage the IDA allocation to the project with additional grant financing.

Ex-post cost-effectiveness analysis of PBF intervention

14. The effectiveness of the proposed PBF intervention has been estimated based on similar schemes implemented in other countries and on qualitative studies conducted during the preparation of the project. However, the impact of the proposed PBF intervention in the specific Tajik context is not currently known. The impact-evaluation (IE) of PBF intervention would allow estimating the effectiveness of the proposed PBF model without or in conjunction with additional Quality Improvement (QI) support (see Annex 7: Impact Evaluation).

15. The effectiveness of the proposed PBF interventions would be identified using a difference-in-differences approach comparing the change over time in coverage and quality of targeted health services in the Rural Health Centers and Health Houses located in the districts where PBF intervention would be introduced and adjoin districts have been identified as potential comparison districts. On the other hand the effectiveness and cost-effectiveness of QI support would be identified using a randomized evaluation design of health facilities located in the districts receiving the PBF intervention.

[31] Article 38 of Constitution of the Republic of Tajikistan.

16. On the base of the effectiveness estimated by the IE the cost-effectiveness of the PBF interventions would be revisited and the new results would inform the Bank, the MoH and other DPs on whether the PBF package should be scaled up to other districts.

Fiscal Impact and Sustainability

17. Total public health expenditure (TPHE) in Tajikistan reached about USD118.72 million in 2011 (see Table 5), which represent a significant increase from the USD48.34 million of public funds allocated to the health sector in 2007. TPHE, measured as a share of GDP increased from 1.3 percent in 2007 to 1.82 in 2011. Regarding the composition of public health spending, the large majority is represented by health spending by local authorities (hukumats) of oblasts, cities and rayons ranging between 63 percent in 2007 and about 76 percent in 2011.

Table 5. TPHE by administration level, 2007-2011, current prices, national currency, TJS millions

	2007	2008	2009	2010	2011
111 Republican budget - MoH	41.89	55.37	54.02	60.23	99.48
121 Local budgets	102.66	162.42	232.41	293.25	393.87
122 Local budgets - special funds	2.95	6.42	8.56	15.33	21.70
113 Public investment program - grants	13.42	30.14	31.17	30.13	12.95
114 Public investment program - loans	5.53	12.49	14.56	0.25	19.24
TPHE	166.44	266.84	340.72	399.19	547.25
TPHE (USD)	48.34	77.81	82.23	91.17	118.72
Gross domestic product, current prices, National currency, millions	12,780	17,609	20,623	24,705	30,069
Gross domestic product, current prices, U.S. dollars, millions	3,712	5,135	4,977	5,642	6,523
TPHE as a share of GDP	1.30%	1.52%	1.65%	1.62%	1.82%

Table 6. Public health expenditures (PHE) in Khatlon and Sogd oblast, estimates after 2011.

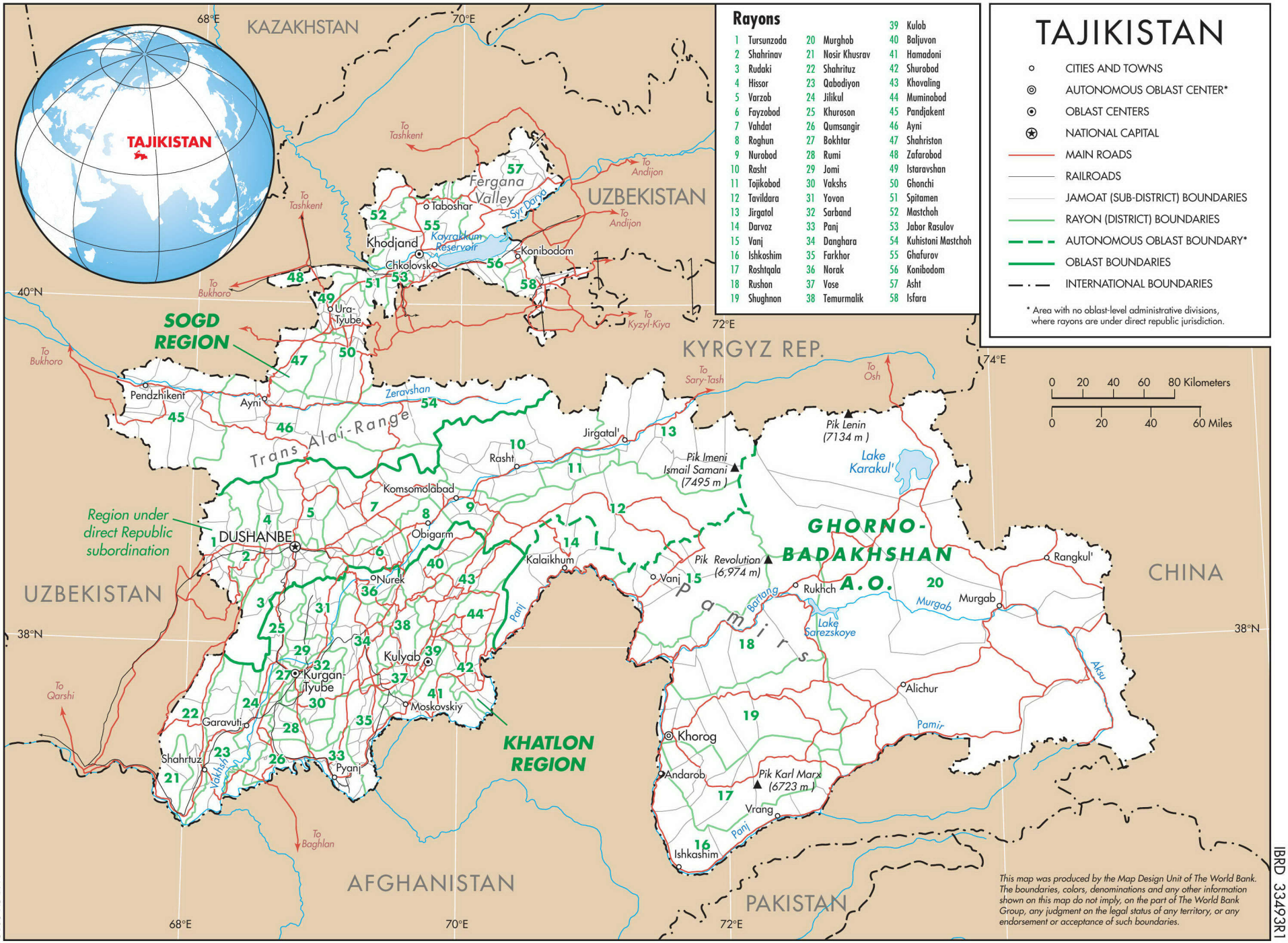
Row Labels	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
210 Khatlon Oblast	28.93	47.59	68.06	94.10	128.63							
237 Sogd Oblast	33.98	54.15	72.74	94.82	126.25							
PHE (national currency, million)	62.91	101.74	140.80	188.92	254.88	314.52	318.37	351.38	399.27	452.91	518.68	593.58
PHE (USD million)	18.27	29.67	33.98	43.14	55.29	68.23	69.07	76.23	86.62	98.25	112.52	128.77
PBF - disbursements							-	0.50	2.50	2.50	2.50	2.50
PBF - disbursements as a share of PHE								0.66%	2.89%	2.54%	2.22%	1.94%

18. Table 6 shows public health expenditures (PHE) in Khatlon and Sogd regions from 2007 to 2018. PHE in Sogd and Khatlon regions has increased significantly in the recent past from 0.49 percent of national GDP in 2007 to 0.85 percent of GDP in 2011. PHE after 2011 has been estimated using the following assumptions: (i) GDP is expected to growth by 7 percent per year over the 2012-2018 period; and (ii) the current low level of resources allocated to the health sector provides space for re-

prioritization of health spending within the Government budget as demonstrated by the rapid increase of TPHE as a percentage of GDP over the last four years[32].

19. PHE in Sogd and Khatlon regions is increasing by about USD10M per year. Therefore, country's future fiscal space should allow to sustain the investment supported by the HSIP beyond its completion and potentially to expand the interventions to additional districts.

[32] See: The World Bank (2013). Policy Note No. 2. Review of Public Expenditures on Health. Tajikistan Policy Notes on Public Expenditures. The World Bank.



Rayons

1	Tursunzoda	20	Murghob	39	Kulob
2	Shahrinav	21	Nosir Khusrav	40	Baljuvon
3	Rudaki	22	Shahrituz	41	Hamadoni
4	Hissor	23	Qabodiyon	42	Shurobod
5	Varzob	24	Jilikul	43	Khovaling
6	Fayzobod	25	Khuroson	44	Muminobod
7	Vahdat	26	Qumsangir	45	Pandjakent
8	Roghun	27	Bokhtar	46	Ayni
9	Nurobod	28	Rumi	47	Shahriston
10	Rasht	29	Jomi	48	Zafarobod
11	Tojikobod	30	Vakshs	49	Istaravshan
12	Tavildara	31	Yovon	50	Ghonchi
13	Jirgatol	32	Sarband	51	Spitamen
14	Darvoz	33	Panj	52	Mastchoh
15	Vanj	34	Danghara	53	Jabor Rasulov
16	Ishkoshim	35	Farkhor	54	Kuhistoni Mastchoh
17	Roshtqala	36	Norak	55	Ghafurov
18	Rushon	37	Vose	56	Konibodom
19	Shughnon	38	Temurmalik	57	Asht
				58	Isfara

TAJIKISTAN

- CITIES AND TOWNS
- AUTONOMOUS OBLAST CENTER*
- OBLAST CENTERS
- NATIONAL CAPITAL
- MAIN ROADS
- RAILROADS
- JAMOAT (SUB-DISTRICT) BOUNDARIES
- RAYON (DISTRICT) BOUNDARIES
- AUTONOMOUS OBLAST BOUNDARY*
- OBLAST BOUNDARIES
- INTERNATIONAL BOUNDARIES

* Area with no oblast-level administrative divisions, where rayons are under direct republic jurisdiction.

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