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Report No: PAD3525

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT
ON A
PROPOSED GRANT

IN THE AMOUNT OF SDR 51 MILLION (US\$70 MILLION EQUIVALENT)
FROM THE INTERNATIONAL DEVELOPMENT ASSOCIATION

AND A

PROPOSED GRANT

IN THE AMOUNT OF US\$3 MILLION FROM THE GLOBAL FINANCING FACILITY

TO THE

REPUBLIC OF TAJIKISTAN

FOR A

EARLY CHILDHOOD DEVELOPMENT TO BUILD TAJIKISTAN'S HUMAN CAPITAL
PROJECT

APRIL 9, 2020

Education Global Practice
Europe And Central Asia Region

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CURRENCY EQUIVALENTS

(Exchange Rate Effective: March 20, 2020)

Currency Unit = TJS

TJS9.75 = US\$1

US\$1 = SDR 0.74

FISCAL YEAR

January 1 - December 31

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ABBREVIATIONS AND ACRONYMS

AKF	Aga Khan Foundation
BP	Basic Package
CCDG	Community Child Development Group
CE	Citizen Engagement
CGDM	Child Growth and Development Monitoring
CPF	Country Partnership Framework
CSP	CASA1000 Community Support Project for Tajikistan
DCC	District Coordination Committee
DLI	Disbursement-Linked Indicator
DRS	Districts of Republican Subordination
ECA	Europe and Central Asia
ECD	Early Childhood Development
ECEC	Early Childhood Education and Care
EEP	Eligible Expenditure Program
eHCI	Early Human Capability Index
ELC	Early Learning Center
EMIS	Education Management Information System
EOP	Executive Office of the President
ESF	Environmental and Social Framework
ESMF	Environmental and Social Management Framework
ESS	Environmental and Social Standard
FM	Financial Management
FTI	Fast Track Initiative
GBAO	Gorno-Badakhshan Autonomous Oblast
GDP	Gross Domestic Product
GFF	Global Financing Facility
GoT	Government of Tajikistan
GPE	Global Partnership for Education
GPE-4	Global Partnership for Education Project
GRS	Grievance Redress Service
HCI	Human Capital Index
IDA	International Development Association
IFR	Interim Financial Report
IMF	International Monetary Fund
IRR	Internal Rate of Return
IsDB	Islamic Development Bank
KG	Kindergarten
L2T	Listening to Tajikistan
M&E	Monitoring and Evaluation

MoES	Ministry of Education and Science
MoF	Ministry of Finance
MoHSP	Ministry of Health and Social Protection
NDS	National Development Strategy
NECDC	National Early Childhood Development Committee
OSI	Open Society Institute
PDO	Project Development Objective
PFM	Public Financial Management
PHC	Primary health care
PHCC	Primary Health Care Center
PIG	Project Implementation Group
PISP	Project Implementation Support Personnel
POM	Project Operations Manual
PPSD	Project Procurement Strategy for Development
PSC	Project Steering Committee
RCT	Randomized Control Trial
SBCC	Social and Behavioral Change Communications
SCD	Systematic Country Diagnostic
SDGs	Sustainable Development Goals
SERSP	Tajikistan Socio-Economic Resilience Strengthening Program
SMS	Short Message Service
TA	Technical Assistance
TJS	Tajikistan Somoni (currency of the Republic of Tajikistan)
TLMs	Teaching and learning materials
TSA	Targeted Social Assistance Program
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WASH	Water, Sanitation and Hygiene
WB	World Bank
WEO	World Economic Outlook



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DATASHEET

BASIC INFORMATION

Country(ies)	Project Name	
Tajikistan	Early Childhood Development to Build Tajikistan’s Human Capital Project	
Project ID	Financing Instrument	Environmental and Social Risk Classification
P169168	Investment Project Financing	Substantial

Financing & Implementation Modalities

<input type="checkbox"/> Multiphase Programmatic Approach (MPA)	<input type="checkbox"/> Contingent Emergency Response Component (CERC)
<input type="checkbox"/> Series of Projects (SOP)	<input type="checkbox"/> Fragile State(s)
<input checked="" type="checkbox"/> Disbursement-linked Indicators (DLIs)	<input type="checkbox"/> Small State(s)
<input type="checkbox"/> Financial Intermediaries (FI)	<input type="checkbox"/> Fragile within a non-fragile Country
<input type="checkbox"/> Project-Based Guarantee	<input type="checkbox"/> Conflict
<input type="checkbox"/> Deferred Drawdown	<input type="checkbox"/> Responding to Natural or Man-made Disaster
<input type="checkbox"/> Alternate Procurement Arrangements (APA)	

Expected Approval Date	Expected Closing Date
30-Apr-2020	30-Nov-2026

Bank/IFC Collaboration

No

Proposed Development Objective(s)

To increase utilization of a basic package of health and preschool education services for 0 to 6 year old children.

Components

Component Name	Cost (US\$, millions)
Strengthening capacity to deliver the Basic Package of Early Childhood Development	4.80



services	
Implementing nationwide selected elements of the Basic Package	9.20
Improving access to the Basic Package in targeted districts	56.00
Project management and coordination	3.00

Organizations

Borrower:	Republic of Tajikistan
Implementing Agency:	Ministry of Finance

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

Total Project Cost	73.00
Total Financing	73.00
of which IBRD/IDA	70.00
Financing Gap	0.00

DETAILS**World Bank Group Financing**

International Development Association (IDA)	70.00
IDA Grant	70.00

Non-World Bank Group Financing

Trust Funds	3.00
Global Financing Facility	3.00

IDA Resources (in US\$, Millions)

	Credit Amount	Grant Amount	Guarantee Amount	Total Amount
Tajikistan	0.00	70.00	0.00	70.00
National PBA	0.00	70.00	0.00	70.00



Total	0.00	70.00	0.00	70.00				
Expected Disbursements (in US\$, Millions)								
WB Fiscal Year	2020	2021	2022	2023	2024	2025	2026	2027
Annual	0.19	5.12	8.76	14.16	13.90	13.41	10.35	7.11
Cumulative	0.19	5.31	14.06	28.22	42.13	55.54	65.89	73.00

INSTITUTIONAL DATA**Practice Area (Lead)**

Education

Contributing Practice Areas

Health, Nutrition & Population, Social Protection & Jobs

Climate Change and Disaster Screening

This operation has been screened for short and long-term climate change and disaster risks

SYSTEMATIC OPERATIONS RISK-RATING TOOL (SORT)

Risk Category	Rating
1. Political and Governance	● Moderate
2. Macroeconomic	● Moderate
3. Sector Strategies and Policies	● Moderate
4. Technical Design of Project or Program	● Moderate
5. Institutional Capacity for Implementation and Sustainability	● Substantial
6. Fiduciary	● Substantial
7. Environment and Social	● Substantial
8. Stakeholders	● Moderate
9. Other	
10. Overall	● Substantial



COMPLIANCE

Policy

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

Yes No

Does the project require any waivers of Bank policies?

Yes No

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

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

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

Legal Covenants

Sections and Description

Schedule 2, Section I.A.1.(a): The Recipient shall establish not later than three (3) months from the Effective Date



and thereafter maintain, throughout the Project implementation, the NECDC with composition and terms of reference satisfactory to the Association and further described in the POM.

Sections and Description

Schedule 2, Section I.A.1.(b) (i) (b): The Recipient shall, through MOF, not later than thirty (30) days after Effective Date, select two deputy coordinators, a procurement specialist, a financial management specialist, an environmental safeguards specialist, a social safeguards specialist, and regional environmental and social safeguards consultants, all with terms of reference and qualifications acceptable to the Association and as further described in the POM.

Sections and Description

Schedule 2, Section I.A.1.(b) (ii) (c): The Recipient shall, through MOF, establish, not later than one (1) month after the Effective Date, technical teams at the ministerial level with staff, resources and terms of reference as further described in the POM.

Sections and Description

Schedule 2, Section I.A.3: The Recipient, through MOF, shall cause the PIG to establish, not later than thirty (30) days after the Effective Date, an automated accounting information system, satisfactory to the Association, for recording Project records and generation of Project financial statements.

Sections and Description

Schedule 2, Section I.A.1.(c): For purposes of implementation of activities under Part 3 of the Project, at the district level, the MOF, through PIG, shall establish with the support of the local government authorities, not later than three (3) months after the Effective Date, DCCs in each selected district to coordinate, facilitate and monitor implementation of the Project activities with a structure, functions and responsibilities, all as further described in the POM.

Conditions

Type	Description
Effectiveness	The Recipient has developed and adopted the Project Operations Manual satisfactory to the Association.
Effectiveness	The Recipient has (i) established a PIG in a manner acceptable to the Association; and (ii) appointed a Project director, and hired a project coordinator, all with terms of reference and qualifications acceptable to the Association.
Disbursement	The Recipient has furnished to the Bank evidence in form and substance satisfactory to the Bank, that the respective DLI (s) has or have been achieved and verified in accordance with the provisions in the POM, and as presented in the corresponding EEP Spending Report; and the Bank has determined, on the basis of the evidence furnished by the Recipient, as set forth in the Verification Protocols, that the DLIs have been satisfactorily achieved, as further



	elaborated in the Project Operational Manual and in the Disbursement and Financial Information Letter.
Type	Description
Disbursement	The Recipient has furnished to the Bank evidence of actual expenditures against each DLI(s) is or are attributed to and evidence that said expenditures have been incurred.



I. STRATEGIC CONTEXT

A. Country Context

- Tajikistan is a low-income country with a sizeable vulnerable population, despite notable accomplishments in poverty reduction.** Tajikistan has a population of 9.12 million.¹ From 2000-2015 the country had an average economic growth rate of 7.7 percent annually and saw dramatic reductions in the poverty rate, from 80 to 31 percent. Yet Tajikistan also had the lowest Gross National Income per capita (US\$990 in 2017) in the Europe and Central Asia (ECA) region. Seventy-three percent of the population is rural and heavily reliant on agriculture: these areas are typically significantly poorer than urban settings, with higher income insecurity during winter and spring months. Service delivery to most Tajiks is challenged by a mountainous terrain, which is 93 percent of the landlocked country. Tajikistan is one of the countries in the region most vulnerable to impacts from external economic shocks, seasonal food insecurity, climate change, exacerbated by its limited capacity to respond to natural hazards. The country is prone to flooding, earthquakes and mudslides, which have a significant impact on social and economic development. From 1992 to 2016, disasters in Tajikistan are estimated to have caused economic losses in excess of US\$1.8 billion, affecting almost 7 million people.
- Women-headed households are significant in volume, and particularly at risk of falling into deep poverty, adversely impacting human development outcomes.** Women's dominant presence in the informal economy makes them susceptible to economic shocks, earning lower salaries, and lacking access to social benefits or opportunities for skills development.² Due to substantial male labor migration to Russia³, 21 percent of households in 2012 were headed by females, of which 60,000 households consisted of single mothers with children.⁴ One in three migrants' wives are left impoverished. Seventy percent of abandoned wives are left providing for children, despite their limited access to finance, social protection, education, or employment.
- Tajikistan's human capital index (HCI) score of 0.53 reflects the urgent need for investment in human capital development.** This means a child born today in Tajikistan is expected to be 53 percent as productive as he or she could be growing up with complete education⁵ and full health⁶. Tajikistan is below the ECA average of 0.63, and regional comparators such as Armenia (0.57), Kyrgyzstan (0.58) and Kazakhstan (0.75). High levels of childhood stunting, and low learning outcomes are the main contributors to Tajikistan's low HCI score.
- Given the overwhelmingly young population in Tajikistan, and the highest birth rates in ECA, investments in quality early childhood development (ECD) services are a development opportunity.** Globally, Tajikistan is among the top 25 percent of the fastest growing populations. Children under 6 years of age comprise 17 percent of the population, and today 1 out of 3 Tajiks are under 15 years of age. At 29 births per 1,000 people in 2016, Tajikistan has the highest birth

¹ Agency on Statistics under the President of Tajikistan, 2019.

² Country Partnership Framework for the Republic of Tajikistan for the Period of FY19-FY23. Washington, DC: The World Bank. 2019.

³ Strokova, Victoria; Ajwad, Mohamed Ihsan. Jobs Diagnostic Tajikistan. Strategic Framework for Jobs. Jobs series, Issue No. 1. Washington, DC: The World Bank. 2017..

⁴ Statistical Agency under the President of the Republic of Tajikistan (SA), Ministry of Health [Tajikistan], and ICF International. Tajikistan Demographic and Health Survey 2012. Dushanbe, Tajikistan, and Calverton, Maryland, USA. 2013; Tajikistan Country Gender Assessment. Asian Development Bank. Manila, Philippines. 2016.

⁵ Defined by the HCI as 14 years of high-quality school by age 18.

⁶ Defined by the HCI as no stunting and 100 percent adult survival.



rate in the ECA region. Between 2015 and 2025, the number of children aged 0-9 is expected to rise by nearly 23 percent, from about 2.2 million to 2.7 million. This demographic trend presents a unique opportunity for Tajikistan to invest in its youngest population as a means of changing its growth and development trajectory. Investing in ECD is critical to achieving the Sustainable Development Goals.⁷ Recent research has shown that developing countries lose up to 12 percent of Gross Domestic Product (GDP) by not building ECD systems.⁸ Given the high economic and social returns to quality ECD investments, interventions to improve child health, access and quality of education, and cognitive and psychosocial development are vital for Tajikistan to achieve and sustain growth through a productive workforce that can respond to a changing global economy.⁹

B. Sectoral and Institutional Context

5. **The Government of Tajikistan (GoT) is committed to investing in multisectoral services to boost ECD outcomes in the country.** Global evidence confirms the importance of simultaneous investment in a range of multisectoral services—parenting programs focusing on health, nutrition and education of the mother and the child (pre-conception to age six); social protection; and water and sanitation—to achieve effective ECD outcomes. The GoT is cognizant of the opportunities presented by investing in the early years and has expressed strong commitment to the development of a multisectoral national program for ECD. However, ECD largely remains defined officially as preschool education. The Government's National Development Strategy (NDS) for 2016-2030 sets an ambitious target to expand access to preschools from 13.3 percent (2017) to 30 percent of its children aged 3-6 years by 2021, and to 50 percent by 2030.

Conception to Age 3

6. **Current child health services in Tajikistan are not systematically monitoring development and promoting ECD, and key opportunities to communicate with parents about the benefit of early child stimulation, and to target at-risk children are being missed.** According to the Tajikistan Demographic and Health Survey 2017, 18 percent of children in Tajikistan suffer from stunting and 3 percent are obese, which reflects the lack of an effective child growth and development monitoring (CGDM) program. Current national guidelines cover nutrition, vaccination and checkups but child development milestones and the content of each checkup are not well defined. Moreover, these are not yet combined in a user-friendly format, and linked to staff training to support high-quality and consistent service delivery. Records and tools do not fully enable health providers to assess, monitor and communicate with parents about weight gain, developmental milestones for motor, cognitive and linguistic skills or socio-emotional development. Figure 1 illustrates skills that are currently not comprehensively monitored at the primary health care (PHC) level. As a result, the system is forgoing key opportunities to better target at-risk children and households and provide extra services at the PHC level to improve nutrition and ECD outcomes. A recent study shows that every dollar invested in interventions targeting ECD and nutrition would yield between US\$4 and US\$35 in economic returns.¹⁰

⁷ B. Daelmans, G.L. Darmstadt, J. Lombardi, M.M. Black, P.R. Britto, S. Lye, ..., L.M. Richter. Early childhood development: The foundation of sustainable development, *Lancet*, 389 (10064) pp. 9-11. 2017

⁸ Richter LM, Daelmans B, Lombardi J et al. with the Paper 3 Working Group and the *Lancet* Early Childhood Development Series Steering Committee Investing in the foundation of sustainable development: pathways to scale up for early childhood development. *Lancet*. 2016; (published online Oct 4.) [http://dx.doi.org/10.1016/S0140-6736\(16\)31698-1](http://dx.doi.org/10.1016/S0140-6736(16)31698-1)

⁹ World Development Report 2019: The Changing Nature of Work. Washington, DC: The World Bank. 2019.

¹⁰ Shekar, Meera; Kakietek, Jakub; Dayton Eberwein, Julia; Walters, Dylan. An Investment Framework for Nutrition: Reaching the Global Targets for Stunting, Anemia, Breastfeeding, and Wasting. *Directions in Development--Human Development*. Washington, DC: The World Bank. 2017



FIGURE 1: AN EXAMPLE OF CHILD DEVELOPMENTAL MILESTONES TO BE ASSESSED IN PHC SERVICES

	Social/Emotional	Language	Cognitive	Motor skills
2 months	Begins to smile at people <input type="checkbox"/> Tries to look at parent <input type="checkbox"/>	Makes gurgling sounds <input type="checkbox"/> Turns head toward sounds <input type="checkbox"/>	Follow things with eyes <input type="checkbox"/> Pays attention to faces <input type="checkbox"/>	Can hold head up <input type="checkbox"/> Begins to push up when lying on stomach <input type="checkbox"/>
4 months	Smiles spontaneously <input type="checkbox"/> Copies some movements <input type="checkbox"/>	Starts babbling <input type="checkbox"/> Imitates sounds he/she hears <input type="checkbox"/>	Follows moving objects with eyes from side to side <input type="checkbox"/> Recognizes familiar people <input type="checkbox"/> Reaches for toy with one hand <input type="checkbox"/>	Holds head steady, unsupported <input type="checkbox"/> Brings hands to mouth <input type="checkbox"/> Can hold a toy and shake <input type="checkbox"/>
6 months	Likes to play with parents and other people. <input type="checkbox"/> Likes to look at self in a mirror <input type="checkbox"/>	Responds to sounds by making sounds <input type="checkbox"/> Responds to own name <input type="checkbox"/> Makes sounds to show joy and displeasure <input type="checkbox"/>	Tries to get things that are out of reach <input type="checkbox"/> Begins to pass things from one hand to the other <input type="checkbox"/> Brings things to mouth <input type="checkbox"/>	Rolls over in both directions <input type="checkbox"/> Begins to sit without support <input type="checkbox"/> Supports weight on legs and might bounce <input type="checkbox"/>
9 months	May be afraid of strangers <input type="checkbox"/> Has favorite toys <input type="checkbox"/>	Understands “no” <input type="checkbox"/> Uses fingers to point at things <input type="checkbox"/>	Looks for things he sees you hide <input type="checkbox"/> Plays peek-boo <input type="checkbox"/> Picks up things between thumb and index finger <input type="checkbox"/>	Stands, holding on to furniture <input type="checkbox"/> Can get into sitting position with help <input type="checkbox"/> Sits without support <input type="checkbox"/>
12 months	Cries when mom or dad leaves <input type="checkbox"/> Shows fear in some situations <input type="checkbox"/> Helps with dressing by putting out arm or leg <input type="checkbox"/>	Uses simple gestures, like shaking head “no” or waving “bye-bye” <input type="checkbox"/> Says “mama” and “dada” <input type="checkbox"/>	Finds hidden things easily <input type="checkbox"/> Looks at the right picture or thing when it’s named <input type="checkbox"/> Puts things in a container, takes things out of a container <input type="checkbox"/>	May stand alone <input type="checkbox"/> Gets to a sitting position without help <input type="checkbox"/> Pulls up to stand, walks holding on to furniture <input type="checkbox"/>

7. **Improving child monitoring will increase the detection of children with developmental delays and/or disabilities, who will require more intensive local support.** Some patients and families will require referral to specialized care for assessment and early treatment. Currently, there are no national training programs for many of these specialized professionals, including speech or occupational therapists. After a period of closure, the specialist training program for pediatricians was re-opened 5 years ago and the first cohort will graduate in 2020. With an improved child development monitoring program, the demand for specialized services will increase, requiring the strengthening of the child development referral pathway (which is the ability of the system to identify a developmental delay at the PHC level and refer a patient, and their family, to the proper specialized services in secondary and tertiary settings). In addition, the system is constrained by challenges with health workers training and availability, economic drivers affecting parent and caregiver awareness and engagement, and a constrained fiscal space for health. Further details on this context can be found in Annex 5.

8. **Within home settings, limited parent and caregiver engagement¹¹ with young children hinders children’s socio-emotional development and is likely driven by economic factors and a lack of information.** Research shows that when family and caregivers are involved, children are likely to have better social skills, show improved behavior and perform better in school.¹² The 2005 Multiple Indicator Cluster Survey revealed that only 44 percent of parents were actively

¹¹ Parent engagement activities can include: reading books; looking at picture books; telling stories; singing songs; taking children outside the home, compound or yard; and spending time with children naming, counting and playing. Parental involvement provides learning opportunities during the critical first 1,000 days of brain development, helps extend teaching outside the classroom, creates a more positive experience for children, and helps children perform better when they are in school.

¹² Lily Eskensen Gracia & Otha Thornton, 2014.



engaged in early stimulation activities, with better performance among the richest quintile (73 percent);¹³ the situation remains the same in 2019. In a 2019 Early Human Capability Index (eHCI),¹⁴ 48.1 percent of caregivers stimulated their children's development with 4 or more activities in the previous 3 days, regardless of caregiver's education level: 38.7 percent of the caregivers had primary education as their highest level of education, 48.5 percent had secondary school education, and 62 percent had tertiary education. Chronic income shortages affecting female headed households are likely to limit time and financial investments in ECD, as well as a household's ability to access information about ECD interventions.

Age 3 to 6 years old

9. **Pre-literacy and pre-numeracy skills are particularly weak in Tajikistan, contributing to low educational attainments in primary education and beyond.** Overall child development outcomes for 3-6 year old children are low in Tajikistan, with a score of 0.54 on a scale of 0 to 1 (eHCI 2019). However, scores are particularly poor in some of the more formal or academic domains of development like pre-literacy and pre-numeracy, likely in part due to the low preschool attendance rates and low quality of education at this level. This has profound impacts on educational outcomes throughout life. Children in Tajikistan can expect to complete 10.8 years of pre-primary, primary and secondary school by age 18. However, when years of schooling are adjusted for quality of learning, this is only equivalent to 7.7 years; indicating a learning gap of 3.1 years.¹⁵

10. **Preschool education is a fledgling and under-resourced subsector in Tajikistan.** The Ministry of Education and Science (MoES) is officially mandated to address ECD and education needs of children 1.5 to 7 years old. The MoES established a preschool education department only in 2018.¹⁶ The budget for preschools increased from 2.1 percent of the total education budget in 2010 to 5.6 percent in 2017, but it remains minimal at 0.3 percent of the GDP, given the need to provide services to a rapidly growing population.¹⁷ Preschool education is fee-based and implemented through: kindergartens (KGs--accounting for 67 percent of the enrolled students), early learning centers (ELCs - 32 percent) and residential facilities (1 percent); this is provided mainly by the public sector (92 percent of institutions), and through a limited number of enterprise-owned and private centers.

11. **Enrollment in preschool education is extremely low and inequitable.** The current preschool enrollment rate (13.3 percent in 2017) is among the lowest in the world, and far below the regional average for Central Asia (37.5 percent). Disparities in access are notable along regional, gender and socio-economic dimensions. Enrollment rates range from 30 percent in Dushanbe to only 2.3 percent in the Districts of Republican Subordination (DRS) region.

¹³ The 2005 Multiple Indicator Cluster Survey. Here, 'active' means engagement in four or more early stimulation activities in the three days preceding the survey.

¹⁴ Brinkman & Sincovich. The Status of Early Childhood Health and Development in the Republic of Tajikistan: Results from a National Survey". 2019. The eHCI is a contextualized instrument used to gather a snapshot of children's holistic development for the age groups from 0-6 years old.

¹⁵ Human Capital Index, The World Bank. 2018.

¹⁶ The pre-primary sector of education suffered most after the devastating civil war following the country's independence in 1991, and many preschool buildings were demolished and abandoned. The Government's tight budgetary situation translated into a de-prioritization of the preschool sector, the high population growth and decreasing quality, led, along with the population poverty level, to a significant reduction in enrollment rates in 1990s and early 2000s.

¹⁷ Between 1991 and 2016, the population of children aged 0-7 grew by around 23 percent (326,000 kids), of which the population of 3-6 year old children rose by around 26 percent (185,000 kids).



12. **Lack of infrastructure, low quality of the existing preschool facilities and the user fee charged for attendance contribute to low enrollment in preschools.** In 2017, there were only 615 KGs across the country, and the coverage was conspicuously low in rural and poorer areas because KGs are mainly located near the more densely populated centers of districts. Physical distance from residence to preschool services is a significant barrier to access across regions, and among families with different socioeconomic backgrounds.¹⁸ Most preschool facilities have unsatisfactory heating, water and sanitation, electricity and communication systems, and classroom lighting, and do not meet the state standards. There is a strong correlation between preschool enrollment and poverty. The minimum monthly fees for preschool that households bear (Tajikistan Somoni-TJS50 per child)¹⁹ accounted for a quarter of the average living expense of people living below the national poverty line in 2017 (TJS190 equivalent to US\$22.40²⁰ per person per month).²¹ Likewise, ELCs charge TJS50 on average per month to households, making ELCs unaffordable for the bottom 40 percent of the population.²²

13. **Quality of preschool services is a concern, especially in rural areas, due to low qualifications of teachers, weak pre- and in-service training programs, and outdated teaching and learning materials (TLMs).** Because only half of professional staff in preschools had a pedagogical degree in secondary or higher education,²³ a major pool of teachers lacks pedagogical competencies. The mandatory preschool curriculum, *Rangincamon* ("Rainbow"), developed in 2010, is not fully implemented in preschools, and it needs an update to make it more relevant for "learning through playing" for age appropriateness of children. Physical infrastructure and quality of learning interactions are poor, especially in rural areas.²⁴

14. **Enhancing access to good quality preschool education will necessitate a multi-pronged strategy.** In light of the above context, recent reports²⁵ point to the need to: (a) expand the definition of ECD to be more holistic and encompass an integrated framework; (b) improve school readiness of six year old children by prioritizing their preschool needs; (c) invest in parental and caregiver awareness, and social mobilization for effective ECD delivery; (d) introduce alternative models of preschool delivery, including KGs, ELCs (public and community managed) and community child development groups (CCDGs); (e) create a regulatory environment that is conducive for private sector participation; (f) increase the budget for preschool sector, with efficiency enhancing initiatives; (g) enhance equity by eliminating user fees for the poorest; (h) invest in upgrading the quality of staff and materials; (i) develop a multisectoral ECD framework; and (j) revise the regulatory framework to accommodate the above.

¹⁸ Early Childhood Education and Care Analysis: A Focused Review of Preschool Education in Tajikistan. Washington, DC: The World Bank. 2019.

¹⁹ Fee ranged from TJS 50-100 (US\$5-11 equivalent) in 2017 and from TJS 55-110 in 2018/2019.

²⁰ As per the average market US\$/TJS exchange rate in 2017 at 8.49.

²¹ The required fee contribution is 150 percent larger than the cash benefits provided to low-income families (TJS 33.3 per household per month, equivalent US\$3.4) by the Targeted Social Assistance program.

²² Early Childhood Education and Care Analysis: A Focused Review of Preschool Education in Tajikistan. Washington, DC: The World Bank. 2019.

²³ Ibid

²⁴ E. Yudina. Preschools' facilities and services assessment. GPE-4 project. 2016.

²⁵ Early Childhood Education and Care Analysis: A Focused Review of Preschool Education in Tajikistan. Washington, DC: The World Bank. 2019; and Brinkman & Sincovich, 2019.



C. Relevance to Higher Level Objectives

15. **The project is aligned with the FY19 – FY23 World Bank Country Partnership Framework (CPF, Report No. 135875-TJ)²⁶ and seeks to address the binding constraints identified in the Systematic Country Diagnostic (SCD).** This project is an important component of Pillar I of the CPF (Human Capital and Resilience) and builds on the SCD's focus on early childhood education and poverty reduction. Project activities will focus on monitoring child growth and development (social, cognitive, language and motor skills) and will address the factors that contribute to nutrition, under-5 mortality and educational opportunity, which have been identified in the SCD and CPF. These areas are also consistent with the World Bank's intention to support the GoT in investing in its people to secure future productivity and competitiveness. The CPF also aims to incorporate gender-sensitive approaches into operations aimed at enabling women to increase their voice, participation and benefits. This project seeks to support gender-relevant considerations through providing improved opportunities for mothers to make informed decisions through acquiring more knowledge about health, nutrition, stimulation and early education of their children, increasing the formal workforce by hiring preschool teachers (who are by nature predominantly female both in Tajikistan and most countries globally), providing upskilling to PHC staff without specialist training (who again are predominantly women), and giving women increased opportunities to seek employment while their young children are in preschool.

16. **As a signatory to the United Nations' Framework Convention on Climate Change (Paris Agreement), Tajikistan is committed to international efforts of reducing or avoiding activities that contribute to climate change.** The CPF aims to support the government's efforts in addressing environmental vulnerabilities, which in Tajikistan include earthquakes, floods, drought, avalanches, landslides and mudslides, and are expected to increase in the coming decades. The CPF states that interventions will seek to create climate mitigation opportunities and adaptation co-benefits, which the project will contribute to in several ways. All works-related activities (construction and rehabilitation) of health and education facilities will incorporate building and construction standards intended to mitigate threats from climate-induced and geophysical hazards. These works will also include energy efficiency considerations, such as through improved lighting, heating, windows and insulation, and appliances, and access to improved water, sanitation and hygiene (WASH) facilities. Further, training curricula for staff at all levels, including administrators, teachers and health care workers, will include materials that seek to increase awareness and understanding in climate change adaptation and mitigation, such as energy and water conservation measures that can be taken in their own workplaces and everyday life, and promoted in sessions with families and communities.

17. **The project will contribute to the government's overall goal of human capital development, as stated in the NDS 2016-2030.** Within the government's focus on human capital development, education, healthcare, water and sanitation, social protection and reduction of social inequality are all identified as priority areas. The Strategy also identifies several specific objectives and results in each of these areas; these include improving access and quality to preschool education to support ECD and implementing measures to enhance children's health and reduce infant and child mortality. The project supports the National Sustainable Development Goals (SDG) Program for Children, launched in November 2019 in Tajikistan, which aims to accelerate the progress towards achieving SDG targets for children by 2030.

²⁶ Discussed by the World Bank Board on May 9, 2019.



II. PROJECT DESCRIPTION

A. Project Development Objective

PDO Statement

To increase utilization of a basic package of health and preschool education services for 0 to 6 year old children.

PDO Level Indicators

- i. At least 60 percent of primary health care centers nationwide report the growth and development status of children 0-3 years old under the program using the child growth and development monitoring program.
- ii. At least 50 percent of children 0-3 years old have received the minimum number of checkups defined in the basic package in the selected districts.
- iii. At least 15 percent of children 3-6 years old in selected districts participating in preschool programs (disaggregated by gender; at least 48 percent of all enrollments are girls).²⁷

B. Project Components

18. **The project proposes to develop and support a Basic Package (BP) of integrated services to tackle the most pressing needs, while building sustainable foundations for cross sectoral service delivery for improved ECD outcomes for all children.** Established and emerging science continues to demonstrate that to promote child development using a holistic approach²⁸ successfully, investments and services must be coordinated and integrated where possible, and concurrently address the health, nutrition, development, education, and protection needs of children, beginning during the preconception period. However, the enabling conditions for multisectoral service delivery, including a common vision, institutional arrangement, and regulatory and coordination mechanisms (for planning, budgeting, implementation and monitoring) remain largely absent. An overall and long-term goal of a government's approach to ECD ought to focus on organizing service provision to ensure that each child will be supported in his or her needs by accessing (a) basic; (b) differentiated, and (c) specialized services.²⁹ Among these services, the project introduces the BP to: (a) ensure that each child's growth and development is monitored systematically across the country; and (b) that children in targeted districts enjoy quality services that promote improved ECD outcomes at an essential level. The BP is further defined in Annex 2.

19. **A long-term approach to service delivery is required to support multisectoral service provision for quality ECD outcomes, integrating basic, differentiated and specialized services.** Building a well-integrated system that can track and strategically provide multisectoral services takes time. Such an effort will require a long-term engagement between the Bank and the GoT for several reasons: (a) the novelty of the concept in Tajikistan, (b) the magnitude of the needs, (c) the long-term nature of investments in ECD, and (d) the complexity of multisectoral service delivery promoting

²⁷ Preschool programs include: center-based programs, like KG, ELC and alternative model such as Community Child Development Groups.

²⁸ Shonkoff, J. P., L. Richter, J. van der Gaag, Z. A. Bhutta. An integrated scientific framework for child survival and early childhood development. *Pediatrics* 129(2). 2012.

²⁹ Good practice in ECD programming emphasizes the importance of defining a package of services promoting improved ECD outcomes, which distinguishes three tiers of services as: (1) basic; (2) differentiated, and (3) specialized services. Basic services that are available to all children includes *inter alia*: immunizations, growth and monitoring check-ups, antenatal care for mothers, and access to kindergartens, preschools and clean water. Differentiated services are extra services to support families in recognition of their different needs, socio-economic status and challenges in access services. Specialized services are for those with developmental requirements such as disability and mental health.



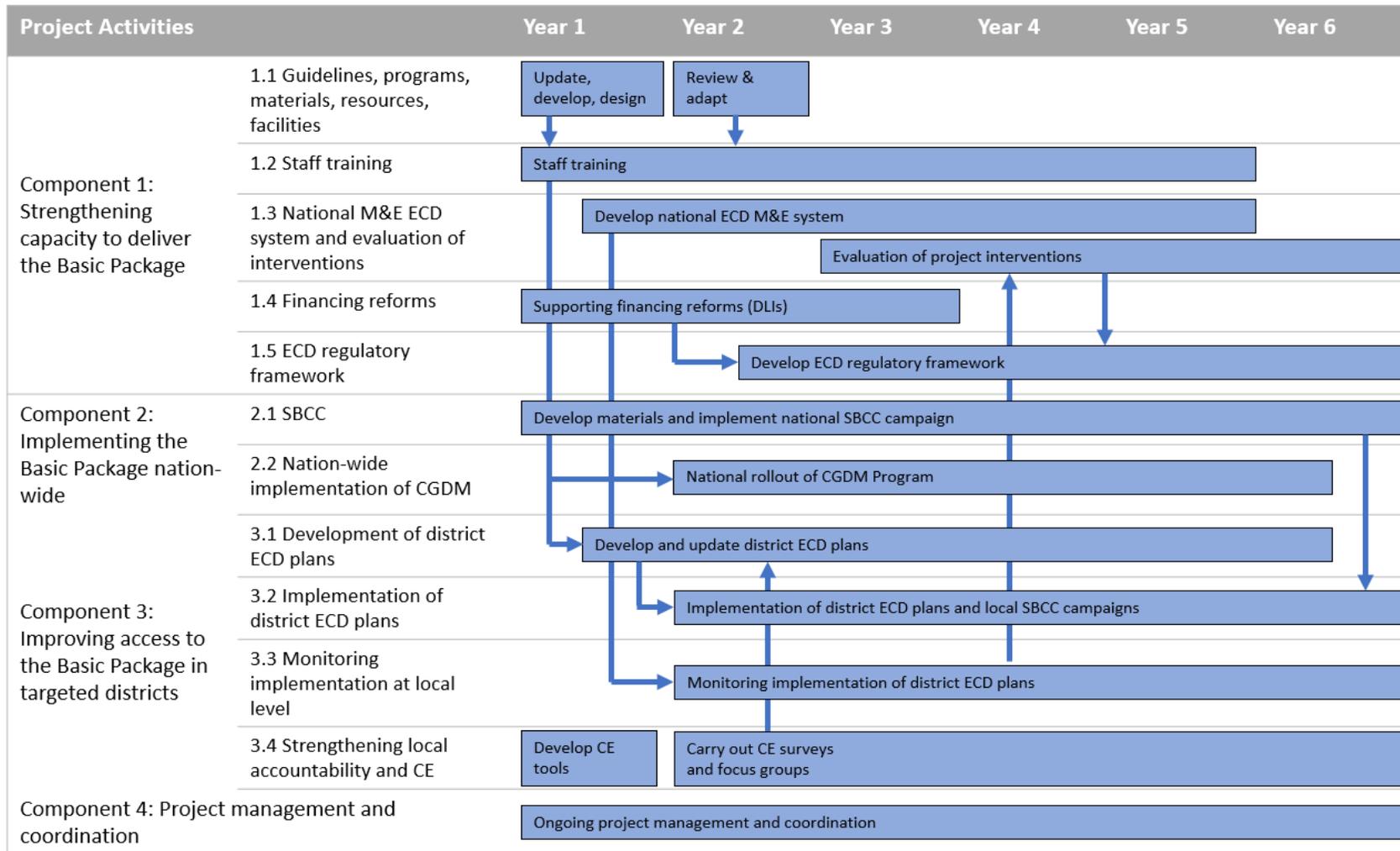
improved ECD outcomes, which requires collaboration and coordination across several ministries and stakeholders, something that is currently very weak in Tajikistan. The proposed project will help establish the foundations for holistic and integrated services promoting improved ECD outcomes at both the national and local levels, while testing the delivery of integrated services where the needs are most urgent. Future phases that could be supported by the Bank could include: (a) further strengthening the regulatory environment supporting multisectoral provision of services promoting improved ECD outcomes; (b) expanding the definition of the BP; (c) scaling up successful targeted interventions to more districts; and (d) continue national and targeted SBCC campaigns, which require long-term and sustained efforts to make an impact on perceptions and behaviors. These are further elaborated in Box A3.1.

20. **Activities under the project will be carried out under four components.** Components 1 and 2 focus on national level interventions, Component 3 focuses on targeted district level interventions, while Component 4 supports project management and coordination. A list of 14 targeted districts for Component 3 interventions have been determined based on transparent criteria with the overall goal of reaching the most disadvantaged households and communities in the country. The final criterion established by the Government was to select districts based on the lowest preschool enrollment rates (below 6.75 percent) in the country and high birth rates.³⁰ Figure 2 displays the key project interventions, estimated timeline for implementation of each activity, and sequencing of dependent activities.

³⁰ The selected districts are: in Khatlon province, Kushoniyon, Vakhsh, Vose, Dusti, Kubodiyon, A. Jomi, Jayhun, Khamodoni; in Sughd province, K. Mastchokh; and in DRS, Varzob, Rudaki, Tajikabad, Faizabad and Hissar.



FIGURE 2: IMPLEMENTATION TIMELINE



Definitions: citizen engagement (CE); disbursement linked indicator (DLI); monitoring and evaluation (M&E); social and behavioral change communications (SBCC)



Component 1: Strengthening capacity to deliver the Basic Package of Early Childhood Development services (IDA: US\$1.8 million; Global Financing Facility-GFF: US\$3.0 million)

21. The objective of this component is to strengthen capacity to deliver a BP that promotes improved ECD outcomes, as defined in Annex 2. There are five sub-components aimed at supporting this objective. Sub-components 1.1, 1.2, 1.3 and 1.5 will be financed using IDA resources, while sub-component 1.4, which utilizes DLIs, will be financed using the GFF co-financing.

22. *Sub-component 1.1: Update and development of the guidelines, programs, materials and resources for implementation of a BP of services for improved ECD outcomes.* The objective of this sub-component is to update or develop the resources needed to support implementation of the BP at the national and district levels. Activities financed by the project under this sub-component will all begin during the first year of project implementation and include technical assistance (TA) for the following:

(a) **Development of BP Manual.** A BP Manual will be developed to provide clear guidance to enable multisectoral planning and implementation of the BP at the district and community level. It will guide all implementers (district administration staff, and staff of primary health care centers (PHCCs) and preschools) on how they work together to serve children in their communities to enhance ECD outcomes. It will include: a detailed definition of the BP; a planning tool to enable local administrations and communities to develop their plans to support implementation of the BP; relevant sections of the CGDM Program manual; guidance on the set up and operation of existing and alternative preschool models, such as CCDGs,³¹ training materials for joint training of health and education staff, and guidance on the use of district funds. This activity will be led by the Project Implementation Group (PIG) under the Ministry of Finance (MoF) and implemented through the MoES and MoHSP.

(b) **Update and standardize prenatal care guidelines.** The prenatal care program will be streamlined to include clinical guidelines for health workers,³² as well as incorporate and strengthen content on parenting awareness and skills, with a focus on ECD and early child stimulation. The guidelines will also include screening and pathways for referrals to secondary care, and promotion of family planning. The project will support an update of the ambulatory cards to be used in PHC services, handbooks for pregnant women and referral forms. Revision of the guidelines will be led by PIG with technical support from MoHSP, positioning them in the driver's seat for a more sustainable approach.

(c) **Update of the national CGDM Program.** This activity will support the MoHSP to include developmental monitoring (covering social, cognitive, language, and motor skills) in child health services, as it is currently not undertaken in the country. Program guidelines will be updated to enhance parental engagement and focus on early child stimulation. This will be facilitated by the introduction of revised guidelines and forms for CGDM; PHC nurses conducting household visits, with a frequency aligned with children's needs and risks; and, a supervision system to monitor the implementation of the program. Review, revision and integration of existing protocols, curriculums and materials for CGDM will also take place. The program will standardize the number and timing of regular checkups; update the ambulatory card (a prototype of this has been widely discussed with the government); provide guidance and checklists for health workers to focus on specific topics, such as growth and nutritional status, immunizations, and the achievement of specific developmental milestones across four critical domains (motor, cognitive and linguistic

³¹ The CCDG is a model that promotes caregiver and child interaction in an educational and stimulating play-based environment.

³² The new/updated guidelines will include updates to the ambulatory card that will include a risk score and an algorithm to strengthen the quality of each prenatal care checkup and clearly define when referrals (for secondary care) are needed.



skills or socio-emotional development). The updated program will also include a bottom-up monitoring scheme that will, on a monthly basis, collect information from the revised ambulatory cards of children that have reached 6, 12 and 24 months in the previous month to identify children that require additional services (household visits or more frequent checkups) and assess the outcomes of the program at the local level. This will enable local health workers to provide additional services to children at risk of not reaching specific milestones and report progress and outcomes of the program to higher authorities. Aggregated information from each PHCC will be reported to the districts, regional and national level, creating a monthly reporting system on the progress of the program and the status of children included in the program.

(d) **Review and adaptation of curricula, equipment specifications, and teaching and learning materials for existing and alternative preschool models.** In order to support rapid expansion of access to preschools, existing curricula and resources for KGs and ELCs will be used for new classroom spaces supported by the project in the early years. These materials will be reviewed, based on the project experience, and updated later in the project for the national scale up (undertaken by the government after the project completion with possible support from a subsequent Bank-supported operation and/or other development partners). Modern preschool teaching approaches like “open space” and “environment as the third teacher” concepts will be reflected in the revised, gender-sensitive and inclusive curriculum too. Further expansion in access to preschool services will be provided through the establishment and operation of CCDGs in targeted districts under sub-component 3.2. As this is a model not currently supported by the GoT, TA will be provided to develop curricula, identify equipment needs, and develop TLMs for CCDGs in the first year of project implementation. A series of policy waivers will be required to implement the preschool models and programs. These will be developed under this sub component. This activity will be led by the PIG with technical support from the MoES.

(e) **Review and Redesign of preschool construction** including existing KG and ELC designs to accommodate the modern teaching approaches mentioned above, and existing building codes to ensure new facilities consider resilience to climate and geophysical hazards, energy efficiency, WASH facility improvements, learning environment (including furniture and other equipment) and consideration of children with disabilities and special needs. Based on this review, revisions will be made to take best practice from international designs, adapted to the Tajik context. These designs will inform construction and rehabilitation of KGs and ELCs in targeted districts under sub-component 3.2.

23. *Sub-component 1.2: Staff training (technical and managerial).* The objective of this sub-component is to strengthen knowledge and capacity of staff (national trainers and administrators/managers) to oversee and implement the BP through training and study visits. To achieve this, the project will finance, in addition to study visits: (a) development of in-service education and training packages for trainers and staff responsible for oversight of implementation and monitoring of the BP on relevant topics, in health and education, at the national level; and (b) training of trainers and managerial staff on the developed packages. The training packages will, inter alia, integrate content on gender targeting and climate change adaptation and mitigation, including energy and water conservation measures that can be taken in the staff workplaces and promoted through their regular work. This activity will be led by the PIG in coordination with the MoES and the MoHSP starting in the first year of implementation and carried out as needed throughout the life of the project.

24. *Sub-component 1.3: Development of a national monitoring and evaluation (M&E) system on ECD and evaluation of the project interventions.* This sub-component aims to support government's capacity to measure and evaluate child development outcomes. These include financing TA for developing an ECD monitoring framework, financing at least two iterations of a national assessment of ECD outcomes, and TA and financing for the development and implementation of surveys to evaluate ECD-related programs supported by the project. These activities will be led by the PIG, with active



involvement from MoES and MoHSP. District administrations will also be involved in the M&E activities related to project implementation, while the Agency on Statistics will be involved in the development and implementation of a national M&E system. These activities will begin in the second year of implementation and continue throughout the life of the project.

25. *Sub-component 1.4: Supporting financing reforms for enhanced services that promote improved ECD outcomes*, through financing payments under the eligible expenditure program (EEP) for PHC services allowing better ECD services, including, greater flexibility to shift funds across budget lines and higher budget execution in PHC. This is a result-based financing subcomponent that includes Disbursement Linked Indicators (DLIs) that will support the introduction of program-based budgeting in district and urban primary health care facilities, including the revision of the budget and expenditure categories that would support the implementation of program-based budgeting by aligning the separate functional category for PHC with the package of services those facilities should offer. Current financing of PHC in Tajikistan may impede rollout of the CGDM Program, as budgets and expenditures are currently by line items. PHC managers have no flexibility in terms of shifting budgets across budget lines. Unexecuted funds, against any budget line, are reallocated by district finance authorities outside of the health sector at the end of the financial year. The supported public financial management (PFM) reform will allow higher budget execution in PHC particularly to pay the salaries of PHC workers who will be implementing the CGDM Program nationwide. The GoT is planning to gradually introduce program-based budgeting in the public sector to improve PFM. The changes in the regulatory framework are planned for the calendar year 2020 and the gradual roll out is expected to begin in 2021. This will particularly support the recruitment and retention of PHC staff, who are the main implementers of the CGDM Program. In order to fully benefit from this opportunity, it is critical that the roll-out of the reforms include the health sector early on.

26. **To incentivize the inclusion of PHC as one of the areas for the early roll-out of program-based budgeting, this sub-component will introduce three DLIs.** The first two DLIs will provide incentives for the changes in the regulatory framework related to the way budgets for PHC are formulated and the way their execution is recorded. More specifically, the first DLI will be linked to the introduction of program-based budgeting in district and urban PHC facilities. The second DLI will be linked to changes in the budget and expenditure categories that would support the implementation of program-based budgeting by aligning the separate functional category for primary health care with the package of services those facilities should offer. The third DLI will provide incentives for the roll out of program-based budgeting in PHC facilities in Tajikistan. These descriptions are provided in Table 1, with full DLI descriptions included in Annex 3. These DLIs will be financed by the full amount of the GFF grant only.

TABLE 1: DLI DEFINITION

DLI Number	Description
DLI1	Adoption of government decree on the introduction in the State Budget of program-based budgeting for district and urban primary health care facilities
DLI2	The Minister of Finance Order No. 173 dated January 26, 2015 on "Economic classification of budget revenues and expenditures of the Republic of Tajikistan" is revised so that (a) the functional classification category 052 and its subcategory 05201 includes the basic package of outpatient services primary health facilities offer (including primary medical care, provision of medicines, and provision of laboratory tests); (b) the functional classification subcategory 05204 concerning health houses is removed; and (c) expenditure category used for recording of the expenditure in primary health care facilities includes the full package of services provided by those facilities (salaries, medicines, utilities, and other expenses).
DLI3	Percentage of district and urban primary health care facilities funded through a separate



	functional classification: DLI 3.1: 44% of district and urban primary health care facilities are funded through a separate functional classification DLI 3.2: 88% of district and urban primary health care facilities are funded through a separate functional classification
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27. **Eligible expenditures to be financed under Sub-component 1.4.** Eligible expenditures related to the activities under Sub-component 1.4 (under DLIs disbursement conditions) will be the health workers salaries at PHC facilities together with associated mandatory payments of the employer like social charges. The proposed Eligible Expenditures are justified under the Project PDO and subcomponent 1.4 activities because PHC services will implement nationwide the new CGDM Program critical to achieve the Project PDO and two of the PDO indicators. In addition, subcomponent 1.4 will provide greater flexibility and reliability of funding flows to PHC facilities through supporting higher budget execution thus protecting the availability of human resources. While subcomponents 1.1 and 2.2 will finance investments to update and implement the CGDM Program including update of the CGDM Program guidelines, printed materials, training, equipment and some rehabilitation works, the main cost of implementation of the CGDM Program will be those associated with ensuring the availability of adequate numbers of qualified health workers at PHC facilities.³³

28. *Sub-component 1.5: Development of an ECD regulatory framework, including governance, financing mechanism, and staffing.* This sub-component aims to support the development of a regulatory framework that would: (a) create an enabling environment for multisectoral ECD service delivery through a range of service options; (b) identify relevant stakeholders and articulate their roles and responsibilities for the provision of the various components of services promoting improved ECD outcomes; and (c) establish national integrated ECD leadership and coordinating structure. To achieve this, the project will finance TA to develop the sector governance capacity, which includes the regulatory framework for public and private sector, capacity building at the central and decentralized levels for integrated planning, supervision and monitoring of service provision promoting improved ECD outcomes, monitoring of ECD outcomes, and financing reforms for sustained provision of services. This activity will be led by the PIG with active involvement of the MoF, MoES and MoHSP and other concerned ministries. Activities will be implemented starting in the second year of implementation.

Component 2: Implementing nationwide selected elements of the Basic Package (IDA: US\$9.2 million)

29. **The objective of this component is to support nationwide implementation of elements of the BP through SBCC and roll out of the CGDM Program.** This will be achieved through two sub-components.

30. *Sub-component 2.1: Social and Behavioral Change Communications.* A comprehensive public awareness campaign and SBCC are essential for reaching the Project Development Objectives (PDOs). A focus on the importance of child development constitutes a significant shift in mindset at different levels of the system: government officials, health and education workers, communities, and families. To achieve this, the project will finance: (a) a stakeholder analysis; (b) a comprehensive Communications Strategy and campaign materials with culturally appropriate messages and approaches to target audiences at various levels to enhance the understanding about the full definition of ECD, including nutrition, responsive care and early stimulation, and alternative early learning interventions; and (c) implementation of the Communications Strategy using a wide range of tools, such as television, newspapers, radio and social media campaigns. This activity will be led by the PIG with active involvement of the MoES and MoHSP, starting in the first year of

³³ This is in line with the 2018 World Bank Guidance on Investment Project Financing with DLIs.



implementation and running throughout the life of the project.

31. *Sub-component 2.2: Nationwide implementation of child developmental monitoring.* This sub-component will finance the production and distribution of materials for the implementation of the updated ambulatory card for pregnant women, and for the implementation of the updated CGDM Program. The sub-component will also finance basic equipment and training to PHC facilities and their staff to implement the CGDM Program nationwide. Training will be provided at the regional level to support nationwide roll-out, recognizing that these Centers can play a role in a multi-pronged strategy for a cultural shift in the monitoring of child development. In addition, under this sub-component, training and the provision of ultrasound and laboratory equipment will be provided at the regional level to support prenatal care and early detection of intrauterine growth restriction, congenital and genetic defects and other conditions that can affect intrauterine and childhood development. This sub-component will also finance training and equipment to district PHCCs that provide rehabilitation services to children. The project will also finance minor rehabilitation of the physical spaces where treatment is provided in these district centers to support further access, treatment and rehabilitation of children referred from rural PHCCs. Revised CGDM guidelines will prompt earlier identification of more at-risk children in need of specialized services. If needed, small works for rehabilitation of these units would be also supported. These district PHCCs and other rehabilitation services will provide regular specialized services to support children with developmental delay (including children with special needs) to resolve or minimize the impact of their conditions, such as physiotherapy or speech therapy. Activities will begin in the first/second year of implementation and continue throughout the life of the project.

Component 3: Improving access to the Basic Package in targeted districts (IDA: US\$56.0 million)

32. **The objective of this component is to support local administrations and communities in targeted districts in developing, implementing and monitoring their ECD plans which are aligned with the goals of the BP.** This will be achieved through four sub-components.

33. *Sub-component 3.1: Development of district ECD plans.* The project will introduce an innovation to help target districts develop integrated ECD plans aimed at delivering the BP. Information for the plans will be obtained from communities/*mahallas*, who will need to be mobilized and informed about the BP and supported in determining their needs, and to develop an optimal mix of solutions to help achieve the BP in their communities. The district staff will be expected to work with the line ministries to finalize *mahalla*-level plans for the development of the district-level ECD plan, with support of the district coordinators. The project will finance: (a) training for district staff in planning, implementing and monitoring implementation progress; (b) TA to develop implementation plans to achieve the BP in target districts; and (c) a targeted SBCC campaign at the local level, which will aim to assess ECD needs, develop integrated ECD plans, enhance family and community support for early childhood stimulation and development, improve parental practices, and empower health workers and educators to support parents and provide quality services that promote improved ECD outcomes at the local level. Training activities will be led by the PIG and implemented through Regional In-Service Institute for Teacher Training, Republican Center for Family Medicine (and its regional branches), Avicenna Tajik State Medical University and medical colleges in the first year of implementation. The detailed mechanisms of the PIG interaction with other stakeholders will be described in the Project Operations Manual (POM). Development of ECD plans will be led by district authorities with TA provided by the PIG in the second half of the first year of implementation. For local SBCC campaigns, materials will be developed by the PIG, and implementation coordinated by district and *mahalla* administrations starting in the second year of implementation throughout the life of the project.

34. *Sub-component 3.2: Implementation of district ECD plans.* The objective of this sub-component is to support local administrations and communities in targeted districts in the implementation of their district ECD plans developed under



sub-component 3.1. Activities will focus on construction and rehabilitation of selected PHCCs and preschool facilities, provision of equipment and supplies to PHCCs and preschools, training for PHCC and preschool staff, and increasing support to nurses implementing the CGDM Program, and existing and new preschool teachers. Some training will be conducted jointly with the MoHSP and MoES to ensure synergies in understanding and messages delivered to families by PHC staff, preschool teachers, and CCDG facilitators. Districts will be supported in the implementation of the District ECD plan (including financing of monitoring, supervision, specific campaigns and petty cash for CCDGs and KGs). Travel for teachers/facilitator training will be financed by the project and managed by the institute for professional development. The following paragraphs provide an overview of what the District ECD Plan may include for different age groups.

For 0-3 years old,

35. **Rehabilitation and construction of PHC facilities, provision of equipment and supplies to PHCCs, and training for PHC staff.** Based on an approved site survey of PHC facilities in project districts to establish physical infrastructure needs, selected PHC facilities will be rehabilitated, or in some cases constructed, to improve access to WASH facilities, quality and safety of existing infrastructure that are resilient to climate and geophysical hazards and energy efficient, and creation of ECD service rooms and settings for ECD programming. Addressing this need will help to build the ability of PHC to support provision of the BP by providing safer, sanitary forums for health workers to deliver the updated CGDM Program. ECD service rooms will provide health workers and parents with a dedicated space and materials to implement the CGDM Program, communicate about parenting and enhance child stimulation. Increased support (training and materials) will be provided so that PHC services are better able to provide prenatal care and guidance to parents on topics such as early stimulation and nutrition in both the center and home settings. In addition, equipment and supplies, and training for the expanded BP will be provided to PHC facilities and workers. This will include: basic ECD-oriented toys and materials for child stimulation; supplies to establish ECD toy libraries; and materials for antenatal care as well as other supplies and equipment.

36. Activities for the 0-3 year old children will be led by the PIG, along with the district-level administrations with technical support from the MoHSP starting in the second year of project implementation, on the basis of the district ECD plan. It is planned that the facility site survey will be undertaken by the State Enterprise on Capital Construction under the MoHSP, with TA provided for verification of the results by an independent international consultant and approved by the World Bank. Existing PHC staff without specialist training will also undergo the six-month retraining course in family medicine at the Provincial Family Medicine Training Centers. It is planned that this component will also finance supervision of the implementation of the CGDM Program through the State Surveillance Service over Medical Activities and Social Protection.

For 3-6 years old

37. **Expanding access to improved early education opportunities in targeted districts.** The objective of this activity is to expand access to preschool education opportunities for 3-6 year old children in targeted districts, with the priority placed on 6 year old children to ensure all children have at least one year of preschool education before starting primary school. This will be achieved by creating and operationalizing more KG and ELC spaces and introducing CCDGs to Tajikistan in existing spaces in the communities, as defined in approved district ECD plans developed under sub-component 3.1.

38. The project will finance: (a) civil works in selected locations for: (i) construction of new KGs, (ii) retrofitting existing



spaces to accommodate new KG students, and (iii) construction and retrofitting of ELCs; (b) establishing CCDGs, including *inter alia*: (A) provision of educational resources for setting up CCDGs; (B) selection and recruitment of facilitators at community level to run CCDGs; (C) provision of training for community facilitators to facilitate and organize CCDGs; (D) provision of training for caregivers in topics related to ECD including health, nutrition and early stimulation; (E) development of materials and production of resources for functional CCDGs; (c) training of teachers, facilitators, coaches and other staff (some sessions jointly with PHC staff); (d) procurement and distribution of appropriate classroom furniture and equipment; (e) production and distribution of TLMs to all KGs, ELCs and CCDGs supported by the project; and (f) periodic coaching visits (at least quarterly) to KGs, ELCs and CCDGs supported by the project. The teaching and learning materials provided to CCDGs will be in sufficient quantity to enable caregivers to borrow materials to take home and read or to play with their children. Local authorities will recruit new KG and ELC teachers, and coaches/methodologists, and are committed to financing the recurrent cost of those KGs (including staff salaries) from their budget. Jointly with the MoES, they will also find ways to fund recurrent costs of ELCs, including through the new preschool financing mechanism to be developed under sub-component 1.5 approved by the MoF. This will help defray the cost of accessing preschools for the lowest income group and is expected to contribute significantly to their ability to participate in preschool services. Communities will select premises for CCDGs (if outside of a public facility) and finance the remuneration of CCDG facilitators if needed.

39. The activities for the 3-6 year old children will be led by the PIG in coordination with district administrations and with technical support from the MoES. Recruitment of staff and production of materials will take place in time for the opening of the preschools, expected to be towards the end of the first year of implementation, followed by training and operation at existing KGs, ELCs, and CCDGs. The CCDGs could operate at KG and ELC or community library venues when available (and even PHC facilities as determined by the community in their district plans). Construction and retrofitting of KGs and ELCs would be completed in the second year followed by enrollment of the new intake.

40. *Sub-component 3.3: Monitoring the implementation progress at district and mahalla level.* The *mahallas* and districts would require data on participation and program quality in order to assess implementation of the BP. Data collection under the CGDM and education management information system (EMIS) is expected to provide the required data for the BP. The CGDM would provide information about health status of the children enrolled in the program at each level of government. The EMIS provides data on enrollments by age and gender for preschools. Additional data collection would be financed, including attendance data of children in ELCs and KGs, and enrollment and attendance data of families in CCDGs. Additional data collection would be designed to be low-cost and sustainable after project completion and restricted to data that is essential for BP implementation and management. Districts will be responsible for data collection and reporting to the PIG and relevant ministries, starting in the first year of implementation. The project will finance: (a) TA to support district- and *mahalla*-level staff in carrying out data collection; and (b) travel costs associated with data collection that are not already covered by the EMIS data collection.

41. *Sub-component 3.4: Strengthening local accountability and citizen engagement.* The project will engage parents and communities in the implementation of activities across the project, building on existing systems to engage parents and community members and working at the community level to identify needs and gaps in services promoting improved ECD outcomes. In addition, as noted above, synergies with the recently approved community-driven development projects, CASA1000 Community Support Project for Tajikistan (CSP)³⁴ and Tajikistan Socio-Economic Resilience Strengthening Program (SERSP)³⁵, offer platforms for deeper engagement working with *mahallas* and

³⁴ P165313 - CASA1000 Community Support Project for Tajikistan

³⁵ P168052 - Tajikistan Socio-Economic Resilience Strengthening Program



community-subcommittees. Two mechanisms for engagement are planned: (a) the (Short Message Service (SMS)³⁶ information and beneficiary feedback mechanism "Mobile Engage" for caregivers and community members; and (b) a participatory planning and monitoring mechanism through women's (or parent) groups to allow local monitoring the performance of their PHCCs and preschools. The project will finance costs related to: (a) modifications to the "Mobile Engage" mechanism and SMS system; and (b) workshops. Preparation activities will begin early in the first year of implementation, with surveys and focus groups starting during the first year and continuing for the life of the project.

Component 4: Project management and coordination (US\$3.0 million)

42. **This component will provide support for the execution of project management and coordination activities.** The component aims to provide daily support for execution of the project interventions to ensure implementation progresses smoothly according to the agreed plan. A PIG will be established with specific responsibilities to provide support and coordinate implementation of project activities. The PIG will comprise experts who meet the requirements defined in each position's terms of reference satisfactory to the Bank. The component will finance: (a) project implementation support personnel (PISP); (b) external consulting services (c) office supplies and equipment; (d) training for PIG and all concerned parties, as needed for project implementation; (e) audits, and operating costs, including travel for study tours and supervision; (f) workshops and conference, as agreed with the Bank, to facilitate good practices and share lessons learned; (g) project M&E activities, project transparency and citizen feedback not covered under component 3; and (h) costs related to a Beneficiary Feedback Mechanism, including a Grievance Redress Mechanism, as described in the Environmental and Social Commitment Plan. Activities under this component will be led by the PIG in coordination with all ministries and targeted district and *mahalla* administrations.

C. Gender

43. The project seeks to address the large and widening gender gap in paid employment.³⁷ By age 25, 70 percent of women have become inactive, meaning they are doing unpaid work at home, compared with 20 percent of men who become inactive at that age. Over 43 percent of Tajik women engage in unpaid home-based work, yard work, and caregiving compared with only 9 percent of men.³⁸ The percentage of households headed by women is growing—often driven by labor migration.³⁹ One-third of men aged 20 to 39 emigrate for most of the year or longer, and about 41 percent of men divorce their Tajik wives after leaving the country.⁴⁰ Around 80 percent of Tajik women in divorce cases are denied property rights and child support. Women cope by taking on traditionally male-led responsibilities, including household maintenance and budgeting, and the tending of fields and animals, on top of their traditional roles as caregivers to children and the elderly. These additional duties limit their participation in education and income-earning activities outside the home. Further, women's paid employment is hampered by the significant decline in the number of preschool educational facilities, especially in rural areas; a result of the collapse of the socialist system and the country's civil war.⁴¹

44. The project supports the gender mainstreaming objectives of the CPF in using gender-sensitive approaches aimed at enabling women to increase their voice, participation and benefits through several activities. The first is the recruitment

³⁶ Short Message Service is a text messaging service.

³⁷ Women's labor force participation declined from 46 to 27 percent between 2003 and 2013. The participation rate among men is 63 percent, according to Tajikistan Systematic Country Diagnostic, Washington, DC: The World Bank, 2018.

³⁸ Statistical Agency under the President of the Republic of Tajikistan, Labor Force Survey.2016.

³⁹ Tajikistan Country Gender Assessment. Asian Development Bank. Manila, Philippines. 2016.

⁴⁰ Tajikistan State Agency on Social Protection, Employment, and Migration.2009.

⁴¹ Tajikistan Country Gender Assessment. Asian Development Bank. Manila, Philippines. 2016; Maternity Protection and the Childcare Systems in Central Asia: National Studies in Kazakhstan and Tajikistan. International Labor Organization. Moscow. 2014.



of an estimated 4,000 preschool teachers under sub-component 3.2, which are expected to be nearly entirely women, based on the existing teacher gender profile in Tajikistan, which follows the trend of most countries globally. Further, activities under sub-component 1.4 aim to improve the funding mechanisms in the health sector, which are expected to lead to flexibility in the use of resources at the local level to hire more health care workers, who again are predominantly women. Also, by providing increased access for children to KGs and ELCs in targeted districts, female caregivers who would normally be required to stay home to care for their children will be provided with opportunities to seek paid employment while their children are in preschool. These activities will increase the number and percentage of women in the formal workforce, providing them with increased economic empowerment, participation in society, benefits and job security.

45. The second set of activities focus on empowerment and voice through increased knowledge and participation in decision-making processes. This includes the upskilling of PHCC workers and preschool teachers in targeted districts, under sub-component 3.2. This is expected to improve their capacity to guide and support young families in raising their children, boosting their own voice and participation in society. Training provided to staff at all levels under the project will also include gender-sensitive content and the importance of gender equality. Also, under sub-component 3.4, women's groups will be involved in participatory planning and monitoring processes, which ensures women have a voice in the design and monitoring of project activities and helps promote women's capacity and status in the community and broader society.

46. The third activity is the increased number and improved quality of information sessions available to caregivers about good parenting practices, gender equality, and the health, nutrition, early stimulation and learning of their children, provided under sub-component 3.2 through PHCCs and CCDGs. These sessions will largely reach mothers and other female caregivers, which improves their own ability and voice in the household in raising their children; however, when male caregivers attend these sessions, which will be promoted through local and national public awareness campaigns using strong male role models, evidence shows this would provide a more supportive male contribution to raising children. By increasing the knowledge of women around caregiving of children, it is expected to improve their empowerment and decision-making in the household. The SBCC campaigns under sub-component 2.1 also aim to improve caregivers' knowledge and understanding of ECD. Topics will include proper nutrition and care of pregnant women, safe environments for all children (girls and boys), and good nutrition and care for babies. All this is expected to have behavioral impacts on the status, care of and support to women and the girl child.

47. Finally, the gap in preschool enrollment between girls and boys (nationally enrollment of girls has hovered around 45 percent for the past decade) will be addressed by the project through public awareness activities under sub-components 2.1 (national campaign) and 3.2 (local communications). Reduction in this gap will be measured through a PDO indicator. In addition, preschool curricula revisions will include gender-sensitive content, intended to instill in children concepts of gender equality and to fight against gender stereotypes from an early age.

D. Citizen Engagement

48. Sub-component 3.4 provides a platform for engaging beneficiaries in the design and implementation of project activities, and monitoring beneficiary feedback on implementation to ensure the services provided are aligned with their expectations. This ensures the voice of beneficiaries is heard at all stages of the project, so the services delivered meet their needs to address the issues impacting poor ECD outcomes. From the beginning of project implementation, beneficiaries will be involved in the development of community ECD plans, which feed into the district ECD plans that determine the activities which will help the district achieve their BP. The beneficiary feedback mechanisms described under sub-component 3.4 aim to ensure that implementation of the district ECD plans is adequately meeting the needs of the communities in improving ECD outcomes for children.



E. Project Beneficiaries

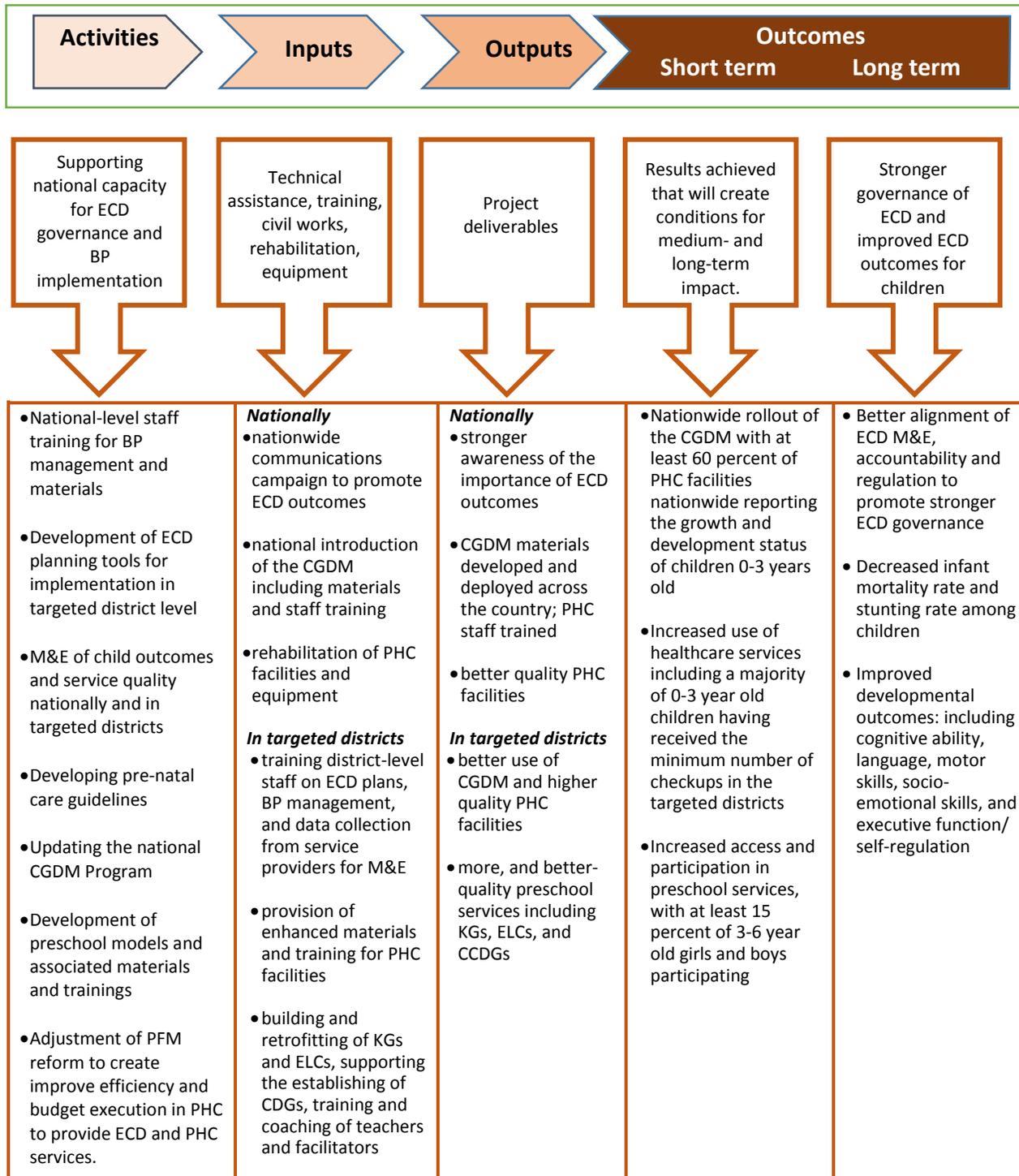
49. **The project supports national level policy development, the delivery of a BP at the national level, and the piloting of enhanced BP in target districts.** In Tajikistan, the annual number of live births is expected to be about 250,000. Hence the national policy development and national BP delivery will benefit 250,000 newborns each year over a 6-year project (or 1.5 million over 6 years), and beyond the project closing. These cohorts of newborns will continue to benefit from the new policies over the period of early childhood, and beyond.

50. **Component 3 interventions in the targeted districts will support children aged 0-3 through the CGDM Program and 3-6 through the preschool program.** The CGDM Program will benefit an average of 200 children per PHCC per year in targeted districts. Total number of beneficiaries from the CGDM Program in 14 targeted districts (25 PHCCs per district) will be a cumulative number of 70,000 children. The establishment of new education services for children age 3 to 6 is estimated to increase KG enrollment by 3,000 children and ELC enrollment by 12,500 children. The establishment of CCDGs is expected to include 37,000 children as well as their caregivers.

51. **The project will also benefit a number of intermediate beneficiaries, including parents and caregivers, nurses and health practitioners, newly recruited and existing preschool teachers in preschool facilities, communities, and district and sub-district level officials.** About 150,000 mothers will receive improved access to antenatal care, and 100,000 young couples will receive family planning and parenting sessions. Parents will receive education sessions to improve parenting practices at home, and in creating a stimulating environment for their children as the first teachers. Around 3,800 preschool teachers will receive training on the principle “learning through playing” and continuous professional support from coaches. Officials at district and village levels will benefit from the project training in planning, budgeting and exercising their autonomy and accountability in implementing an approved ECD plan at the district level.



F. Results Chain





G. Rationale for Bank Involvement and Role of Partners

52. **Both the World Bank and the GoT are committed to poverty reduction by developing human capital, with a focus on ECD.** Tajikistan's HCI score of 0.53 in the context of a very young and fast-growing population points to the importance of focusing on ECD programming to better support the future economic and social potential of the country. While the health and education sectors have faced financing challenges on account of the wider macroeconomic context, the current political momentum around ECD represents an important political window that the Bank is well positioned to support and foster. The Bank will assist the GoT in closing both the policy gap (Component 1) and the financing gap for critical interventions (Components 2 and 3). Moreover, the Bank has deep experience in the local context, having worked in health and education in Tajikistan for approximately two decades. The Bank will also bring in relevant expertise and coordination with other projects in its portfolio, including the Rural Water Supply and Sanitation Project⁴², Social Safety Net Strengthening Project⁴³, SERSP and the CSP. As a starting point of collaboration, community mobilization efforts across these projects will be informed by the ECD project to support communities in advancing their health and education planning for better ECD outcomes.

53. **From a technical and stewardship perspective, the Bank's extensive experience in education, health, and early childhood programming affords it with the ability to bring technical expertise and support a coordinated approach amongst development partners.** The Bank's contribution comes from having supported more than 75 ECD projects since 1990, and more than US\$1.6 billion in lending across 47 countries. The Bank has extensive expertise in supporting large-scale ECD projects. In addition, the breadth of the World Bank programming in Tajikistan affords the World Bank with the ability to convene and engage a wide range of partners. In the design of the project, the World Bank has drawn upon the guidance and country experience of development partners⁴⁴ to identify the most effective activities and opportunities for potential collaboration. These partners are supporting different elements of ECD, and agree to harmonize with the World Bank, and leverage the national integrated approach to ECD that is being developed under this project as a foundation for linking the various interventions across the country. Thus, the project will use the ELC's programs for 3-5 year old children developed and used by AKF and UNICEF projects, and will build on the communication and awareness raising campaign materials developed by UNICEF, AKF and OSI. Different working groups to develop technical materials (programs, protocols, manuals etc.) will be jointly supported by the development partners to avoid duplication of efforts and gaps in delivery. The project will work with UNICEF and AKF in developing ECD M&E instruments (such as preschool quality and school readiness assessment).

54. **The project will establish very close collaboration and engagement with all key ECD government stakeholders and development partners.** Signaling the importance of human capital investment, project representatives will join partnerships and leverage existing platforms aimed at increasing domestic support for the ECD movement in Tajikistan. Project representatives will regularly participate and collaborate with such mechanisms and platforms as the National Health Council, the GFF National Platform, Reproductive, Maternal, Neonatal, Child and Adolescent Health Coordination Council, Development Coordination Council Working Group on Health, and Development Coordination Council Working Group on ECD, and the National Scaling Up Nutrition Platform.

⁴² Rural Water Supply and Sanitation Project - P162637

⁴³ Social Safety Net Strengthening Project - P122039

⁴⁴ Contributions have been made by the United Nations Children's Fund (UNICEF), the United States Agency for International Development (USAID), the Islamic Development Bank (IsDB), Aga Khan Foundation (AKF), Open Society Institute (OSI) and other partners.



55. **Currently, under the MoHSP, several streams of work are being completed or initiated on ECD with the support of development partners, with the risk of duplication or lack of integration.** For instance, the World Health Organization is developing an ECD Framework for Tajikistan and introducing a Pocket Guide on management of common childhood illnesses at the PHC level. Japan International Cooperation Agency and UNICEF have developed and distributed a “Maternal and Child Health Handbook” (*Rohnamoi solimii modar va kudak*) in selected districts. UNICEF is working on finalization and approval of a 1,000 days SBCC Strategy, an early detection and early childhood intervention program, establishment of pedagogical, medical, psychological consultation services at the PHC level and nurturing care framework, a tool for growth and development monitoring, and new ECD curricula at health worker training institutions. Moreover, the USAID will be launching a new US\$13 million project focusing on maternal and child health. Project activities can support the MoHSP to lead, guide, and streamline efforts of development partners working on ECD in the health sector to maximize the benefits of these initiatives while ensuring integration. Thus, the project can assist the MoHSP in developing one nationwide approach on ECD activities in the health sector, including harmonized national protocols, materials, and training curricula.

56. **Tajikistan has recently (May 2019) joined the GFF in support of Every Women and Every Child.** The GFF Trust Fund acts as a catalyst for financing, with countries using modest GFF Trust Fund grants to significantly increase their domestic resources alongside the World Bank's financing, aligned external financing, and private sector resources. Each relatively small external investment is multiplied by the countries' own commitments, generating a large return on investment, contributing to lives saved, and to the accumulation of human capital. The GFF is providing co-financing to this Project, namely financing the DLIs.

H. Lessons Learned and Reflected in the Project Design

57. **A multisectoral approach to design and implementation.** The project design incorporates lessons learned from global best practices and research in ECD, as well as almost two decades of health and education programming in Tajikistan and Central Asia. The intention to focus on facilitating a multisectoral approach draws on extensive experience of successful programs in Latin America. For example, Chile's Crece Contigo program is based on a comprehensive multisectoral management model which ensures access to a set of universal services for every child from gestation to preschool, along with a combination of differentiated and specialized actions aimed simultaneously at the children themselves and their family for as long as they need it. The ECD systems in Chile, Australia, Finland and other countries recognize caregivers as the first actors called upon to provide adequate nurturing care to their children to enable them to reach their full potential. The project aims to build a foundation for a national multisectoral mechanism to develop ECD policies and provide services promoting improved ECD outcomes in a coordinated and holistic way. Also, given the current weak institutional capacity in Tajikistan, and the lack of avenues for multisectoral coordination, the BP is designed to provide an overarching objective for all entities to plan their contribution to delivery of services promoting improved ECD outcomes in targeted areas.

58. **The project design has also been informed by key challenges faced in the implementation of 17 ECD programs worldwide, namely the framing of ECD interventions and sectoral entry points, workforce challenges, and scaling up.** A review⁴⁵ of the design and implementation of 17 national ECD programs identified the following lessons. Using sectoral entry points and strengthening existing systems can support vertical and horizontal integration of new ECD programs. Developing communication channels between sectors is a critical step towards being able to effectively draw upon and maximize the scope offered by each sector. One way to build consensus across multiple partners is to

⁴⁵ Benton et al., Investing in Children: A scoping review of international experience in early childhood development. Washington, DC: The World Bank (forthcoming, 2019).



establish a representative body, with clear strategic direction and financing, to provide cross-sectoral oversight and coordination. Drawing on standardized M&E tools can help to ease the challenges associated with scale up, including maintaining quality and developing effective approaches to M&E. Often, service providers are not supported enough by regular or quality training or mentorship, which reflects inconsistency in financing, training and monitoring systems. Embedding training and supervision into service delivery models can help to ensure regular contact and build the capacity of frontline workers, supervisors and managers, particularly where it encourages problem solving and ownership.

59. **Sustained and institutionalized training and capacity strengthening.** Previous World Bank projects and guidance from development partners with extensive experience in ECD programming in Tajikistan has informed the approach to training, supervision mechanisms and implementation. Previously, World Bank projects⁴⁶ have effectively drawn on Regional Family Medicine Training Centers and In-service Teacher Training Institutes as forums for providing training designed at the national level to ensure better uptake and ease of dissemination on the one hand and strengthening the system's capacity on the other hand. Furthermore, effective training should be organized as direct as possible to trainees and accompanied with regular coaching and support, as centralized and one-off training has shown little impact in improving quality and practices. With regards to supervision of the CGDM Program, the State Surveillance Service over Medical Activities and Social Protection is being used for the current Health Services Improvement Project and has built familiarity with supervision requirements for human development programming. Finally, discussions with development partners, such as UNICEF and the Aga Khan Development Network (AKDN), highlighted the importance of measures to facilitate national sustainability. For example, through the range of pilots that have been supported by development partners it has become clear that drawing on existing services and programs is important in enabling ownership, a key pre-requisite for sustainability.

60. **Strong M&E to ensure quality of service delivery.** Previous Education for All - Fast Track Initiative (FTI) Grants were instrumental in developing and improving procedures and instruments for supervision and monitoring. In particular, the MoES elaborated and improved the mechanism of civil works supervision. In the area of training, the MoES developed tools and mechanisms for monitoring logistics, participant satisfaction, trainer quality, and participant performance. Further, the FTI Grants helped to promote a culture of M&E within the MoES, such that activities are generally only supported if provision is made for M&E. Accordingly, the M&E instruments and procedures developed under prior FTI Grants will be integrated into the current project, as well as various complementary M&E exercises (e.g., an evaluation of training effectiveness in changing teaching-learning practices).

61. **Community mobilization and involvement to ensure relevance and ownership of interventions.** The project draws on the community mobilization experience under several World Bank and other donor-supported projects⁴⁷ to identify effective approaches to community engagement. The project makes use of existing participatory planning and oversight processes at the community level to provide locally-identified infrastructure and strengthens the capacity of community/*mahalla* administrations and community-level institutions to engage with citizens and to deliver services efficiently, fairly, and in response to the needs of the community. The Tajikistan Global Partnership for Education Project (GPE-4)⁴⁸ supported community mobilization activities to raise awareness and advocate for the importance of early learning among rural communities. As a result, the demand for preschool programs has increased in the target areas and the parents' expectations from preschool programs shifted from school preparation to school readiness.

⁴⁶ Tajikistan Health Services Improvement Project (HSIP) - P126130; series of Fast Track Initiative (FTI)/Global Partnership for Education (GPE) grants for Tajikistan.

⁴⁷ Tajikistan Socio-Economic Resilience Strengthening Project (SERSP) – P168052, Japan Social Development Fund Nutrition Grant Scale-Up Project, GPE-4 Project, AKDN projects.

⁴⁸ Global Partnership for Education Project (GPE-4) - P131441



62. **Delivering preschool services cost effectively through alternative models.** The intent is to promote innovative ECD models (home-based parenting engagement, half-day preschools, CCDGs (also known as playgroups) with volunteers) which have proven successful in quickly expanding access by mobilizing social capital and participation of parent caregivers and communities in countries that faced similar resource, capacity and geographical constraints for service delivery (e.g., Indonesia, Tonga). The model also produced successes in well-resourced environments like Australia, with the findings from a quantitative evaluation⁴⁹ demonstrated that playgroups are universally beneficial to all children from a range of different backgrounds, and that playgroups have positive impacts on all domains of child development: physical, social, emotional, language and cognitive development, and communication. Community playgroups (models of the CCDGs planned under this project) supported by development partners in Tajikistan have already proved to be effective in remote mountainous areas of the country. The ELCs representing a half-day model in Tajikistan were the main driver of the rising preschool enrollment in the last decade.⁵⁰

63. **Communications play a key role in improving household and community understanding and effecting behavior change around ECD.** Research from a variety of contexts demonstrates that community-based communication can effectively change behavior in a cost-effective manner. Likewise, practical coaching sessions have the power to change behavior after a relatively short period of time. The project will design practical sessions to reinforce parents' and caregivers' skills in quality interactions to build self-confidence in parents and caregivers to engage successfully with their children. Beneficiary access to contextualized communication and mass media messages can rapidly improve feeding practices at scale. In Bangladesh, for example, delivery of a community-based communications package, developed with assistance from Alive and Thrive, was associated with a more than 30 percent improvement in key indicators – exclusive breastfeeding and consumption of a diverse diet – over 3 years.

64. **Regulatory foundations critical to complement interventions.** The previous World Bank and other development partners' operations in Tajikistan, Uzbekistan and Kyrgyzstan demonstrated the importance of undertaking related measures in public administration and financing areas for the sustainability of alternative preschool models. Thus, the half-day preschool models introduced in those three Central Asia countries obtained sustainability in Kyrgyzstan and Uzbekistan, but not Tajikistan. In Tajikistan, the ELCs, although legally recognized as a form of preschool services provision accommodating almost one-third of children enrolled in preschool, still lack secured public funding and a regulatory framework, limiting their quality and sustainability. In the other mentioned Central Asia countries, the ELCs have state co-financing and inclusion of the ELCs' teachers in the public payroll. The project aims to develop and pilot the financing mechanisms for sustainability of the proposed program and interventions.

65. **Cost effectiveness and minimum standards of construction and rehabilitation of buildings.** Experience from analytical work and projects in the Kyrgyz Republic around seismic retrofitting and reconstruction of schools shows the importance of identifying gaps in planning and design of education and health facilities in current building codes, and to define a 'minimum standard' of services and functional improvements for retrofitting/construction of educational or health facilities to be supported under Bank financing. The aim is to provide the greatest developmental impact of these activities in a cost-efficient manner, while also avoiding risks associated with poor quality of works. As this project attempts to help the government in its goal to rapidly expand access to preschool and improve the condition and safety of PHCC facilities, it will need to define a 'minimum standard' for the construction and rehabilitation carried out, with the goal of also informing government regulations for its own efforts towards expansion and improvement of services.

⁴⁹ Gregory, T., Harman-Smith, Y., Sincovich, A., Wilson, A., & Brinkman, S. It takes a village to raise a child: The influence and impact of playgroups across Australia. Telethon Kids Institute, South Australia. ISBN 978-0-9876002-4-0. 2016.

⁵⁰ Early Childhood Education and Care Analysis: A Focused Review of Preschool Education in Tajikistan. Washington, DC: The world Bank. 2019.



66. **Pilot, learn and universalize.** Implementation of structural reforms (including in financing) should be thoroughly prepared and piloted. Tajikistan has successful experience in conducting education and health financing reforms. The gradual move to per capita financing in general education and PHC after the pilots provide solid experience for the project, which intends to pilot new alternative preschool models and their financing. It is envisaged that the Government will allow piloting of the new financing mechanisms in the target districts. The opportunity to pilot digital materials in one district for the CGDM Program, depending on the success of the planned activities in this area and availability of the financial resources, will be considered during the implementation of the project.

III. IMPLEMENTATION ARRANGEMENTS

A. Institutional and Implementation Arrangements

67. **Effective ECD service provision requires a multisectoral vision that is owned by all key stakeholders.** An integrated ECD project is complex by nature as it addresses multiple needs and services, requiring coordination in planning, implementing and monitoring by diverse agencies and service providers. As mentioned earlier, there is a lack of regulatory and institutional mechanisms for developing and implementing activities that promote improved ECD outcomes holistically. In fact, the current regulatory regime creates both overlaps and gaps in tasks between government agencies with respect to the developmental needs of children ages 0-7 years old. Nevertheless, the two key line ministries (MoHSP and MoES) have many existing service delivery channels that will need to be coordinated closely to enable service delivery to improve ECD outcomes.

68. **Given the multisectoral nature of the interventions, the GoT will establish a National Early Childhood Development Council (NECDC)** chaired by the **Deputy Prime Minister for Social Sectors**, with the **Minister of Finance** as deputy chair, and comprising ministers of all concerned ministries, including MoES, MoHSP and others (Labor, Agriculture, Water, etc.), and the Executive Office of the President. The NECDC is the venue to convene various ministries and agencies involved in ECD service delivery to: (a) guide the development of ECD policies; (b) provide strategic orientation of medium- and long-term ECD plans aligned with the country's development objectives; and (c) monitor project implementation performance, and provide oversight and support to resolve bottlenecks as required for smooth implementation of the project. The NECDC will be supported by the PIG with the Project Coordinator acting as the Secretary of the NECDC (see below for detail). The NECDC is the highest level that will review the ECD policy documents drafted by the project before submitting to the Government for final approval.

69. **The MoF will hold responsibility for the project implementation and host the PIG.** Project implementation requires multisectoral involvement, and the most appropriate agency to lead this coordination is the MoF, which is the GoTs' focal point for the World Bank Human Capital Project. The MoF is therefore a key player that can bring together all concerned ministries and agencies to deliver the results of the project. The MoF will be responsible for overall implementation, coordination, results monitoring, and communicating with the Bank on implementation of all project-related activities. Thus, all project activities will be led by the MoF with support from MoES and MoHSP. The **Minister of Finance** will appoint a **Deputy Minister, responsible for Investment Policy, to be the Project Director** to lead project implementation and monitoring, in close collaboration with the MoES and the MoHSP. The Project Director will be able to delegate signatory authority to an Executive Director to speed implementation as required. The MoF will hire PISP and consultants who will provide technical and operational assistance for project implementation (under the PIG).

70. **A central PIG will be established within the MoF.** The PIG's vital roles are to provide technical and operational



assistance to MoF, MoES, MoHSP and targeted project districts in implementing the project activities, including procurement, financial management (FM), and environmental and social risk management responsibilities. The **Project Coordinator** will be hired by the MoF to lead the PIG based on terms of reference acceptable to the World Bank. The Project Coordinator will be working closely with **two Deputy Coordinators**, PISP positions to liaise closely with management and all relevant departments of MoES and MoHSP to: (a) ensure alignment of planning, budgeting, implementation and monitoring; (b) prepare technical proposals and provision of technical oversight to project activities for institutionalization and sustainability; and (c) implement selected project activities and monitoring others activities. In addition, the PIG will also include other international and local consultants and experts or consulting companies on different technical areas as required for project implementation, including procurement, FM and environmental and social due diligence, and M&E. An international advisor/consultant is also expected to be recruited to support the project management team, as required. At the district level, a **District Coordinator** will be located in each target district to provide technical and operational support and ensure smooth coordination, implementation and supervision at the district and *mahalla* levels.

71. **The MoES and MoHSP will play major roles in implementing the project activities, in coordination with district administrations under the leadership of the MoF.** Close collaboration between the two line ministries will be required to ensure harmonized implementation, efficiency in use of resources, avoidance of overlap, and to create a new integrated approach to providing services for the benefit of children. A **Technical Team** will be established within each line ministry to work together, with technical and operational assistance of the **Deputy Coordinators and PIG**, in planning, implementing and monitoring project activities. The MoES and the MoHSP will also be expected to appoint **Deputy Minister(s)** responsible for ECD issues to lead the respective ministerial Technical Teams.

72. **Component 3 activities of the project will be implemented in targeted districts.** In each district supported by the project, the local government authority will establish a project **District Coordination Committee (DCC)** to coordinate, facilitate and monitor implementation of project activities in that district. The DCC will be headed by a Deputy Chair of the local government authority and comprise key departments related to ECD: finance, health and social protection, education, communications, WASH, and construction. The DCC will be supported by a District Coordinator hired by the MoF/PIG and located at the district level.

73. **Mahalla level.** Most of the project activities and inputs for achieving the BP's expected outputs will be implemented at the *mahalla* level. Therefore, the communities are expected to play a critical role in identifying their needs, setting priorities and contributing to developing the district ECD plan to achieve the BP. **Mahalla Committees** will facilitate implementation, with support from the *Jamoat*.

B. Results Monitoring and Evaluation Arrangements

74. **Results monitoring for the BP will be implemented through the data collection activities described in Components 1 and 3.** Data from the CGDM system would provide measurement of PDO Indicator (i), and, in conjunction with population data, PDO Indicator (ii). For PDO Indicator (iii), the EMIS and additional data collected under Component 3.3 would provide the number of children enrolled in CCDGs, ELCs, and KGs. Enrollment rates would be calculated using population numbers. The national survey of child development (eHCI, see Annex 1, sub-component 1.3) would provide an additional estimate of participation rates in preschool programs to help verify PDO Indicator (iii). Intermediate indicators would be collected primarily through the EMIS, and additional data collection described in Components 1 and 2.



75. **Evaluation strategy.** Targeted activities under the BP (support and training for PHC facilities, new and upgraded KGs, ELCs, CCDGs) will be evaluated by comparing targeted and non-targeted districts. Data collected under Sub-Component 1.3 includes a survey to assess child development (eHCI) as outcome measures and surveys to assess service provider quality (including PHCC and classroom observation tools) as process measures. Child development outcomes will be measured at baseline and end-line. Service provider quality measures would be conducted at baseline as well as mid-line and end-line. Mid-line service provider surveys will provide an initial evaluation of the effectiveness of the training provided to allow for updating or changes to the training and coaching methods in the second half of the project.

C. Sustainability

76. **Technical sustainability:** Several measures are being taken under the project to ensure sustainability of successful project interventions. The project will be implemented using existing government systems, and following government policies and regulations, which will be reviewed and revised as required, so that the regulatory framework is in place by the end of the project. The government has agreed to provide counterpart funding for recurrent costs (such as teacher salaries and operating costs of PHC facilities and preschools), which will provide a budget line item for the expansion of services during project implementation. A large and enduring SBCC campaign, as well as engagement with communities, will also lay the foundations to guide families and communities to step up and meet gaps in service delivery. The project will support the development of a regulatory and financing framework for further institutionalization of the reforms by establishing string foundations for multisectoral ECD programming and investments. Finally, the project provides the foundations for scale up of successful interventions within an enabling regulatory framework by government with support from the Bank, other development partners, and the private sector in Tajikistan.

77. **Financial sustainability:** The project will have important financial implications to the public financing as seen in the Economic Analysis section, due primarily to the expanded coverage of basic services. While the expansion of the services, including ELCs and CCDGs, uses a relatively cost-efficient model with private (household) contributions, the institutionalization of services requires recurrent expenditures, including *inter alia*: operating costs, training and coaching, and monitoring.

IV. PROJECT APPRAISAL SUMMARY

A. Technical, Economic and Financial Analysis (if applicable)

A1. Technical Analysis

78. **The project will engage a multisectoral approach to achieving enhancements in children's physical, cognitive, and non-cognitive development.** The project consists of a two-pronged approach, improving the existing services and platforms where available, while expanding access to and improving quality of services promoting improved ECD outcomes. The project will simultaneously support policy development and strengthen the institutional capacity and systems necessary to institutionalize the service delivery platforms.

79. **Recent research has emphasized the role of early years in child development, and focused on a well-rounded approach to ECD, recognizing that many factors influence child development.** The literature today shows that the model of child development emphasizes an integrated approach to address the complex interplay between biological



factors, environmental factors and the social factors arising from the caretaking environment. The project will take the comprehensive approach by offering a BP of interventions that address these factors, including *inter alia*: the provision of prenatal care to reduce the risk of maternal infection during pregnancy (biological); a child growth, development and health monitoring program and parental support and education to improve the caretaking environment and early education programs for stimulating learning experiences (environmental); and play and communication activities to promote caregivers' responsiveness (social).

80. **The proposed project provides a BP of key services that are key to improving ECD outcomes.** Building on the existing framework of basic, differentiated and specialized services to mitigate against biological, environmental and social risk factors, the BP offers a package of interventions focused on basic services. These packages are broadly grouped as interventions for children of prenatal to age 3, and age 3-6.

81. **For children up to 3 years of age, introducing a focus on developmental milestones is a core theme, which draws on international good practice.** Across the world, ministries of health, social protection and education have collaborated to develop CGDM programs. A key part of these programs are materials emphasizing developmental milestones, such as walking and talking. A prototype for a revised ambulatory card, which drew on international examples, has been discussed with the MoHSP. This dialogue focused on adapting international examples, in order to respond to challenges facing Tajik health workers. For example, considering the large volume of patients seen by a Tajik health worker, the prototype condenses child development milestones into a checklist so more time can be spent engaging with patients than on paperwork. The updated CGDM Program will build a bottom-up monitoring system that will provide valuable and timely information to the local (PHC) level so that health workers can provide extra support to children at risk. It will also provide aggregated information to district, regional and national levels for policy and resource adjustments at these levels. In addition, the project proposes to improve stunting rates by improving infant and young child feeding through counselling in health facilities. This is intended to help ensure the minimum acceptable diet in the 1000-day window. Antenatal care will also be improved, with the aim of reducing premature birth and other risk factors for growth and developmental delay.

82. **The BP to target children aged 3-6 would focus on the access to preschool and children's school readiness, with special focus on one full year of preschool for children ages 6/7 years.** The BP offers a menu of different interventions that districts would be able to adopt, including the traditional KG model, the emerging ELC model, and the newly proposed CCDGs. These options offer an expansion of quality preschool services by mobilizing social capital and improving parenting practices to serve a larger target population. The project offers support to policy development at the national level and implementation of the policies through extensive rollout in the target districts. This approach allows the country to develop a comprehensive policy and institutional framework for ECD and achieve concrete ECD outcomes delivered through the selected districts through focused capacity building and implementation support.

A2. Economic Analysis

83. **Justification of public financing.** The primary economic justification of public financing of early age child development and education is the inability of households to borrow against future earnings of their children. Despite strong evidence of high benefits in terms of future productivity and earnings relative to costs of early age interventions, credit constraints prevent individuals from borrowing against future earnings to finance early interventions: this market failure is the primary justification for public intervention for ECD in general and applies to this project as well.

84. **World Bank value-added.** The World Bank's value-added is its experience and expertise in implementing and evaluating ECD interventions previously in many different contexts. The World Bank has extensive experience



supporting and evaluating ECD investments and policy reforms internationally. This includes supporting the upgrading of early childhood education and care services including preschools, early learning centers and kindergartens, and it has been integral in the development and evaluation of playgroup in Indonesia and the South Pacific.

85. **International evidence of effectiveness of interventions.** A large number of studies have evaluated the effects of nutrition and maternal health interventions on child growth outcomes and of early stimulation interventions on child development more broadly (see Annex 4 for details). This research motivates integrating ECD interventions, however, capacity including supervision, training, and monitoring is crucial to the success of these programs. Emerging evidence, including a recent randomized control trial (RCT), has shown positive effects of playgroups especially for disadvantaged children. A large body of evidence, including long-term RCTs, have shown the effectiveness of high quality center-based ECEC for child development, schooling outcomes, and adult labor market outcomes including earnings.

86. **Cost-benefit methodology.** While it is not possible to quantify the effects of the interventions targeting 0 to 3 year old children, international studies have found substantial benefit-cost ratios through improved survival rates, early detection of diseases, improved future health, and better schooling and productivity. The interventions targeting 3 to 6 year old children have been evaluated previously in various countries and provide a range of possible effect sizes to expect in Tajikistan and allow the modeling and estimate of an internal rate of return (IRR). A lower bound IRR was estimated based on the benefits of the interventions targeting 3 to 6 year old children through improved cognitive outcomes only, excluding subsequent benefits of increased schooling and other private and social benefits. Because neither the effect of cognitive outcomes of the interventions nor the effect of cognitive outcomes on future earnings and productivity is known in advance in Tajikistan, a range of IRRs are calculated based on the range of effects of the interventions evaluated in other contexts and on the return to cognitive skills estimated in other countries. This range provides a sensitivity analysis for the lower bound IRR estimate (see Annex 4 for modeling assumptions).

87. **Lower-bound IRR for interventions targeting 3 to 6 year old children.** The estimated IRR of the interventions targeting 3 to 6 year old children is 8.49 percent. The sensitivity analysis provides a standard deviation of potential lower bound IRR of 3.26 percent. This is a lower-bound estimate and the true IRR is expected to be substantially higher as expected costs are lower and benefits higher than the lower-bound model's assumptions. This lower-bound estimate is sufficient to justify the project as discount rates, since ECD projects are typically 3 to 6 percent given that they are long-term investments spanning more than one generation.

88. **Fiscal implications of the project.** Recurrent costs required by the government to support the project's activities during implementation and maintain the project's activities after completion represent a small fraction of current health and education expenditure. When fully implemented, the interventions targeting 0 to 3 year old children represent 0.34 percent of domestic government health expenditures while the interventions targeting 3 to 6 year old children represent 0.46 percent of the national public education budget. This includes additional teacher salaries and materials for the increase in 3 to 6 year old children using ECEC services resulting from the project (see Annex 4 Tables A4.5 & A4.6 for details).

A3. Financial Analysis (if applicable)

Not applicable

B. Fiduciary

(i) Financial Management



89. Responsibility for the project's FM will rest with the MoF, which will maintain a satisfactory project accounting system, capable of tracking all project resources and expenditures and generating regular financial statements. The FM arrangements of the MoF have been assessed to determine if these arrangements (budgeting, accounting, reporting, internal control, staffing, funds flow and audit) are satisfactory to the Bank.

90. The FM arrangements of the MoF meet minimum requirements. Although the MoF does have experience in implementing World Bank projects, no FM specialist experienced in FM of the Bank funded projects has been assigned to the project as yet. An Action Plan has been agreed to be implemented to bring the FM arrangements to satisfactory status. These actions include: (a) hiring of a FM Specialist by the project effectiveness; (b) development of an FM Manual as part of the Project Operations Manual and within the timeline of the Project Operations Manual by project effectiveness; and (c) installation of fully functional accounting software for the project (within 30 days of effectiveness) to have the capacity to generate unaudited interim financial reports (IFRs) as well as attachments of withdrawal applications including statement of expenditures and annual financial statements.

91. The audit of the project financial statements will be conducted by (i) independent private auditors acceptable to the Bank, on ToR acceptable to the Bank, and (ii) according to the International Standards on Auditing (ISA) issued by the International Auditing and Assurance Standards Board of the International Federation of Accountants (IFAC). Annual audits of project financial statements will be provided to the Bank within six months after the end of each fiscal year, and also at the project closing. The Recipient has agreed to disclose the audit reports for the project, within one month of their receipt from the auditors, by posting the reports on the website of the MoF. Following the Bank's formal receipt of these reports from the Recipient, the Bank will make them publicly available according to World Bank Policy on Access to Information. Quarterly Interim Unaudited Financial Reports (IFRs) will be used for Project monitoring and supervision. These financial reports will be submitted to the Bank within 45 days of the end of each calendar quarter. As part of the project implementation support and supervision missions, quarterly IFRs, audit reports and audit management letters will be reviewed, and regular risk-based FM missions will be conducted. More details on FM arrangements will be provided in the Project Operations Manual. The overall FM risk rating was assessed as Substantial.

92. For the Eligible Expenditure Program (EEP) (staff compensation expenses of the primary health facilities, together with respective mandatory payments of the employer like social charges, etc.), the project will rely on the current financing scheme and rules on budgetary appropriations and reporting existing at MoF which is straightforward and managed in an acceptable way. The project will use government reports as the basis of disbursement (reimbursement of a portion of executed expenditures under the EEP) upon achievement of results for DLI-based financing elements, and a Statement of Expenditures methodology (traditional disbursement mechanism) for other elements of the project. The details of the disbursement arrangements and EEP budget execution report format will be described in the Disbursement and Financial Information Letter.

93. Because the DLI-based disbursement reimburses expenditures, the government's expenditures under the EEPs in a period must be greater than the amount of the DLI that the project financing will disburse over the same period. Disbursements will go directly to the Treasury single account without any conditionality or encumbrance. Since the timely allocation of EEP budgets to the PHC facilities is essential for meeting EEP and DLI conditions, while disbursement will flow to the MoF, it is expected that the DLI-based component will prove mutually beneficial to both and promote closer collaboration. The MoHSP and MoF may decide to use part of the funding to increase funding for the PHC



facilities in line with the strategies and programs that will be adopted with the project's support. This will be left for the government to determine.

94. **Verification of Results under sub-component 1.4 of the Project.** The Recipient shall, during the implementation of the Project and prior to disbursing any payment related to the achievement of Disbursement-Linked Indicators #3, carry out or cause to be carried out, in accordance with terms of reference acceptable to the Bank, and the detail further elaborated in the Project Operations Manual, an independent verification of the achievement of said targets for which future payments will be made under sub-component 1.4 of the Project.

(ii) Procurement

95. Procurement under the project, including sub-component 1.4 with the use of DLIs, will be governed by the World Bank's Procurement Regulations for IPF Borrowers (July 2016, revised November 2017 and August 2018) (Procurement Regulations), and will also be subject to the Bank's Anti-Corruption Guidelines (dated July 2016).

96. The Project Procurement Strategy for Development (PPSD), including procurement plan for the project duration, has been developed by the MoF in coordination with the MoES and the MoHSP, and with close support of the Bank. Analysis of the PPSD shows that envisaged procurement activities and packages are typical for the sectors integrated in the project and are small in value. The investments mainly include rehabilitation/construction of facilities, provision of learning and teaching materials, furniture and equipment, and communications campaigns and trainings. The market analysis has confirmed the availability of competitive markets for key packages.

97. The overall procurement risk under the project is currently assessed as Substantial. The key issues and risks concerning procurement include: (a) quality issues during execution of civil works; (b) procurement and implementation delays due to increased volume of procurement activities in multiple projects implemented in parallel and the need to coordinate procurement process with multiple project implementation partners and stakeholders; (c) insufficient technical expertise; and (d) limited contract monitoring and management skills and tools. Given the above risks, the following preliminary risk mitigation measures are proposed: (a) quality assurance of civil works, including hiring of third party quality assurance and control consultants; (b) increasing procurement capacity through hiring of procurement staff to provide assistance with day-to-day delivery of the services and intensive training of PIG staff; (c) putting in place an efficient contract monitoring mechanism; and (d) establishing a group of experts to provide technical inputs to procurement processes. Further details are provided in the PPSD.

98. **Use of National Procurement Procedures.** In accordance with paragraph 5.3. of the Procurement Regulations, when approaching the national market (as agreed in the Procurement Plan), the Tendering with Unlimited Participation procurement method and other national procurement arrangements such as tendering with limited participation, request for quotations, direct contracting set forth in the Law of the Republic of Tajikistan "On Public Procurement of Goods, Works and Services", # 168 dated March 3, 2006 (as amended by Law #815, the "Law of the Republic of Tajikistan on "Introduction of Amendments and Additions to the Law of the Republic of Tajikistan on 'Public Procurement of Goods, Works and Services'" dated April 16, 2012) ("the PPL") may be used, subject to the conditions referred to in the Procurement Plan.

C. Legal Operational Policies



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

D. Environmental and Social

99. The environment risk is rated moderate and social risk is rated substantial; therefore, the overall Environmental and Social Framework (ESF) risk level is substantial, due primarily to the fragile social conditions, the remoteness and number of planned activities, and inexperience of the client delivering the ESF. Key risks relate to the following: (a) fragility and conflict situation prevailing in certain parts of the country; (b) poverty and unemployment situation which in turn impact women; (c) inclusion - likely that some poor and vulnerable households may find it difficult to participate in the project; and (d) weak client capacity and uncertain coordination arrangements required for a multisectoral project. A Social Assessment has been conducted and the following instruments have been prepared and disclosed on government and World Bank websites: (a) Environmental and Social Management Framework (ESMF); (b) Stakeholder Engagement Plan; (c) Resettlement Policy Framework; (d) Labor Management Procedures; and (e) a Social Assessment.

100. On the environmental front, as a mitigatory measure, the client has prepared and disclosed an ESMF since the project is financing a broad range of small and medium scale activities, most of which will not be identified until after implementation begins. The ESMF covers the applicable ESF Standards, namely Environmental and Social Standard (ESS) 1 – Assessment and Management of Environmental and Social Risks and Impacts, ESS 2 – Labor and Working Conditions, ESS 3 – Resource Efficiency and Pollution Prevention and Management, ESS 4 – Community Health and Safety, ESS 5 – Land Acquisition, Restrictions on Land Use and Involuntary Resettlement, and ESS 10 – Stakeholder Engagement and Information Disclosure; as well as the World Bank Group’s Environmental Health and Safety Guidelines. All construction work will be carried out in accordance with building standards that take into consideration the impacts of climate and geological hazards such as floods and earthquakes. Existing government building standards for preschools and PHC facilities will be reviewed and revised as necessary. Further, curricula for staff being trained under the project will integrate content on climate change adaptation and mitigation, including energy and water conservation measures that can be taken in their workplaces and promoted through their regular work.

101. Tajikistan’s HCI, which indicates the level of human capital opportunity as well as full health, is quite low – expected 53 percent (as against 100 per cent adult survival with no stunting and completing 14 years of quality school education by age 18). The HCI is a composite result of several parameters viz., the several social services. Tajikistan encounters several challenges in ensuring effective social services. There are over 800,000 children 0-5 years of age. Despite economic progress and gains in stability, the life of the typical child in this age group remains uncertain. Poverty is a major constraint and is having a particularly large impact on young children and on women because of the special vulnerability of these segments of the population. Significant unemployment has led to large-scale migration, especially among men leaving women behind to head households, thus making them responsible for supporting their families, as well as carrying out their other domestic duties and taking care of children. All these have impacted early child development and in turn on human capital development and poverty reduction in the country. In this context, the ECD project assumes significance as it is expected to contribute significantly towards meeting Tajikistan’s goal of quadrupling preschool coverage for children aged 3-6 years by 2030 – an increase from about 12 percent to 50 percent. Key social development issues identified in this endeavor are: (a) accessibility – to poor and near-poor people, especially in rural and peri-urban areas; (b) equity - as a result of geographical, socio-economic, and inter-regional disparities; (c) fragility and conflict-ridden situations in some border areas; (d) gender inequity – to ensure reaching out to women in general and female



headed households in particular; (e) adequate and appropriate facilities provision and service quality; and (f) regulation and governance, especially integrating health and education sector activities. The majority of the interventions are expected to be more 'soft' in nature – analytical and advisory services, capacity building and capacity support, equipment, development of curricula etc. However, some small-scale civil works are envisaged. Further, to accomplish its ultimate goal, ECD will have to develop synergies with other projects and programs.

102. Given the above multi-faceted dimensions, social risk is rated 'substantial'. Towards managing the same, the following ESSs are highly relevant to the project (in adopting the ESF): ESS 1, ESS 2, ESS 5, and ESS 10; instruments for these have been developed to address these standards.

V. GRIEVANCE REDRESS SERVICES

103. Communities and individuals who believe that they are adversely affected by a World Bank (WB) supported project may submit complaints to existing project-level grievance redress mechanisms or the WB's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address project-related concerns. Project affected communities and individuals may submit their complaint to the WB's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WB non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate Grievance Redress Service (GRS), please visit <http://www.worldbank.org/en/projects-operations/products-and-services/grievance-redress-service>. For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.

VI. KEY RISKS

104. **The overall risk is Substantial.** The key risks identified at this stage relate to institutional capacity for implementation and sustainability of project activities beyond the closing date; fiduciary; and social risks.

105. **Institutional capacity for implementation and sustainability risk is considered Substantial,** arising from the multisectoral nature of the project, and the reliance on two leading line ministries to come to agreement to ensure implementation momentum. A proposed mitigation measure envisaged is the establishment of a NECDC chaired by the Deputy Prime Minister for Human Development and assigning MoF the role of project implementing agency with coordinating power across ministries. The NECDC will review cross sectoral policies related to ECD, while the MoF will take a lead role in planning, steering, and monitoring the project performance. MoF will be assisted by a PIG - a group of international and local experts who will provide technical and operational support as well as in the fields of M&E, procurement, FM and safeguards which would mitigate risks identified. To support implementation at the local level, the project will hire District Coordinators.

106. **Fiduciary risks are considered Substantial.** No complex procurement and financial transactions are anticipated in the project, and the implementing agency has prior experience in managing fiduciary functions under the World Bank and other donor-funded projects over the past years. Detailed fiduciary assessment of the implementing agency was conducted during the appraisal. The proposed fiduciary rating will be either re-confirmed or updated based on the outcomes of the assessment. In the meantime, the Bank team is providing support to the MoF team in developing the PPSD.



107. **Social risk is considered Substantial in reference to the prioritized districts responsible for project interventions.** Project implementation will be carried out in diverse districts, which are exposed to common conflict and fragility risks that could have a bearing on the project outcomes. The border vulnerability and the absence of sustainable job opportunities and income-generating activities has led to unemployment and poverty which has proven to be a key push factor incentivizing individuals to join extremist groups. Certain segments are particularly exposed to such risks -- women and youth. The project areas are thus characterized by (a) geographical- inter-regional and international/cross border risks; (b) economic risks – high rate of unemployment, in particular among youth, and significant dependency of household income on remittances which is vulnerable to external economic conditions and fluctuations; (c) social risks – the project's clientele chiefly involves poor and vulnerable households/communities, therefore ensuring effective inclusion will be a challenging task as certain sections could be excluded either due to inherent structural deficiencies and/or elite capture; and (d) institutional risks – inadequate capacity of the client in the application of ESSs. While the first two risks remain external to the project, the remaining risks need to be addressed. A developed list of non-eligible activities for the district ECD plans includes activities that may result in physical and/economic displacement, cause negative impact on income/livelihood resources, imply unequal pay for equal work for women and men, finance private goods, government offices or religious buildings, involve activities that use forced/child labor, etc. Yet, there are remote chances of acquisition of 'lands' and hence there are resettlement-related risks as well. To reduce a burden of preschool fees on the households and thus to increase access to preschool services for poor children, the government will provide co-financing for recurrent cost of ELCs and the project will support discussions on the revision of the Targeted Social Assistance (TSA) Program to include benefits for the poor related to participation in preschool programs. Also, a comprehensive public awareness campaign and SBCC will focus on the importance of child development including nutrition, responsive care and early stimulation, and alternative early learning interventions to launch a significant shift in mindset of communities and families to actively utilize ECD services. A limited capacity of the client to apply ESSs will be mitigated by coaching from a TA and implementation support from the Bank team.



VII. RESULTS FRAMEWORK AND MONITORING

Results Framework

COUNTRY: Tajikistan

Early Childhood Development to Build Tajikistan’s Human Capital Project

Project Development Objectives(s)

To increase utilization of a basic package of health and preschool education services for 0 to 6 year old children.

Project Development Objective Indicators

Indicator Name	DLI	Baseline	Intermediate Targets					End Target
			1	2	3	4	5	
To increase utilization of a basic package of health and preschool education services								
Percent of primary health care centers nationwide reporting the growth and development status of children 0-3 years old under the program using the child growth and development monitoring program (Percentage)		0.00	0.00	10.00	20.00	40.00	50.00	60.00
Percent of children 0-3 years old that have received the minimum number of checkups defined in the Basic Package in the selected districts (Percentage)		0.00	0.00	0.00	10.00	15.00	30.00	50.00



Indicator Name	DLI	Baseline	Intermediate Targets					End Target
			1	2	3	4	5	
Percent of children 3-6 years old in selected districts participating in preschool programs (Percentage)		5.00	5.00	5.60	7.10	9.30	11.80	15.00
Percent of girls 3-6 years old in selected districts participating in preschool programs (Percentage)		45.00	45.00	45.20	45.60	46.30	47.10	48.00

Intermediate Results Indicators by Components

Indicator Name	DLI	Baseline	Intermediate Targets					End Target
			1	2	3	4	5	
Strengthening capacity to deliver the Basic Package								
Ministerial order approving updated Child Growth and Development Monitoring Program (Yes/No)		No	No	Yes	Yes	Yes	Yes	Yes
Number of administrators received training in Early Childhood Development management and monitoring (Number)		0.00	0.00	50.00	200.00	250.00	300.00	300.00
Percentage of district and urban primary health care facilities funded through a separate functional	DLI 3	0.00	0.00	0.00	10.00	44.00	88.00	88.00



Indicator Name	DLI	Baseline	Intermediate Targets					End Target
			1	2	3	4	5	
classification (Percentage)								
Implementing the Basic Package nationwide								
Number of primary health care workers trained in the implementation of the Child Growth and Development Monitoring Program (Number)		0.00	0.00	600.00	800.00	1,200.00	1,500.00	1,800.00
Number of primary health care facilities equipped for implementation of the Child Growth and Development Monitoring Program (Number)		0.00	0.00	1,000.00	2,500.00	2,500.00	2,500.00	2,500.00
Number of children enrolled in the Child Growth and Development Monitoring Program (Number)		0.00	0.00	80,000.00	300,000.00	500,000.00	700,000.00	1,000,000.00
Percentage of children who are developmentally on track as reported by CGDM program (Percentage)		0.00	0.00	50.00	60.00	70.00	70.00	80.00
Improving access to the Basic Package in targeted districts								
Number of health facilities that are rehabilitated and/or constructed (Number)		0.00	0.00	70.00	140.00	200.00	280.00	280.00
Number of new classrooms created through construction or rehabilitation (Number)		0.00	0.00	0.00	200.00	350.00	450.00	550.00



Indicator Name	DLI	Baseline	Intermediate Targets					End Target
			1	2	3	4	5	
Number of children 3-5 years old receiving preschool programs (Number)		0.00	0.00	5,000.00	10,000.00	20,000.00	30,000.00	40,000.00
Number of girls 3-5 years old receiving preschool programs (Number)		0.00	0.00	2,300.00	4,700.00	9,600.00	14,400.00	19,200.00
Number of children 6 years old receiving preschool programs (Number)		0.00	0.00	0.00	2,500.00	4,800.00	8,000.00	12,500.00
Number of girls 6 years old receiving preschool programs (Number)		0.00	0.00	0.00	1,200.00	2,300.00	3,800.00	6,000.00
Number of teachers, facilitators and coaches completed professional training under project (Number)		0.00	0.00	680.00	1,350.00	2,000.00	3,000.00	3,800.00
Number of coaching sessions conducted (Number)		0.00	0.00	2,700.00	5,400.00	8,000.00	12,000.00	15,000.00
Students benefiting from direct interventions to enhance learning (CRI, Number)		0.00	0.00	5,000.00	12,500.00	24,800.00	38,000.00	52,500.00
Students benefiting from direct interventions to enhance learning - Female (CRI, Number)		0.00	0.00	2,300.00	5,900.00	11,900.00	18,200.00	25,200.00
Percentage of beneficiaries who report that citizen engagement processes are		0.00	0.00	50.00	60.00	70.00	80.00	80.00



Indicator Name	DLI	Baseline	Intermediate Targets					End Target
			1	2	3	4	5	
effective (Percentage)								
Percent increase of caregivers attending primary health care centers and Community Child Development Group sessions who report improved decision making in the household (Text)		TBD						TBD - baseline + X%
Number of preschool teachers employed in project-supported preschools (Number)		0.00	0.00	100.00	400.00	800.00	1,300.00	1,900.00
Number of female preschool teachers employed in project-supported preschools (Number)		0.00	0.00	95.00	380.00	760.00	1,230.00	1,800.00

Monitoring & Evaluation Plan: PDO Indicators

Indicator Name	Definition/Description	Frequency	Datasource	Methodology for Data Collection	Responsibility for Data Collection
Percent of primary health care centers nationwide reporting the growth and development status of children 0-3 years old under the program using the child growth and development monitoring	Percent of nationwide public primary healthcare facilities submit monthly report about health status of children 6, 12 and 24	Monthly	CGDM Program	Every month, each PHC center reviews and reports the health status of children that reached 6, 12 and 24	PHC Workers



program	months old			months in the preceding month.	
Percent of children 0-3 years old that have received the minimum number of checkups defined in the Basic Package in the selected districts	Percent of children enrolled in the CGDM program in the selected districts reached a satisfactory number of checkups at the 6, 12 and 24 months evaluation	Monthly	CGDM Program	Every month each PHC center reviews and reports the health status of children that reached 6, 12 and 24 months in the preceding month.	PHC Workers
Percent of children 3-6 years old in selected districts participating in preschool programs	Preschool programs include center-based programs, like KG, ELC and other alternative models, such as playgroups or home-based	Annual	EMIS and data collection from CCDGs	EMIS collects data from ELCs and KGs; data collection from CDGs would be additional.	EMIS
Percent of girls 3-6 years old in selected districts participating in preschool programs	Females enrolled in preschool programs, including center-based programs, like KG, ELC and other alternative models, such as CCDGs	Annual	EMIS and data collection from CCDGs	EMIS collects data from ELCs and KGs; data collection from CCDGs would be additional	EMIS

Monitoring & Evaluation Plan: Intermediate Results Indicators

Indicator Name	Definition/Description	Frequency	Datasource	Methodology for Data Collection	Responsibility for Data Collection
Ministerial order approving updated Child Growth and Development Monitoring Program	Ministerial order approving updated Child Growth and Development Monitoring Program	Annually	Project reports		PIG



Number of administrators received training in Early Childhood Development management and monitoring	Number of administrators that receive training in Early Childhood Development management and monitoring (cumulative).	Annual	Project reports	Reporting on trainings to administrators	PIG
Percentage of district and urban primary health care facilities funded through a separate functional classification	The GoT is planning to gradually introduce program-based budgeting in the public sector to improve public financial management. This intermediate indicator will monitor the roll out of program-based budgeting in primary health care facilities in Tajikistan	Annually	MoH budget		MoF and MoH
Number of primary health care workers trained in the implementation of the Child Growth and Development Monitoring Program	Total number of PHC workers that were trained in the updated CGDM program (cumulative).	Biannual	Training reports	Training reports submitted to the MoHSP	MoHSP/Training Providers
Number of primary health care facilities equipped for implementation of the Child Growth and Development Monitoring Program	Number of PHC facilities equipped (cumulative).	Annual	Project report	Reception reports	PIG
Number of children enrolled in the Child Growth and Development Monitoring Program	Total number of enrolled children that received the 6 month old evaluation (cumulative).	Monthly	CGDM Program	Every month each PHC center reviews and reports the health status of children that reached 6, 12 and 24 months in the preceding month.	PHC Workers



Percentage of children who are developmentally on track as reported by CGDM program	Percentage of children included in the CGDM program reported as developmentally on track	Yearly	CGDM program reporting system		MoHSP
Number of health facilities that are rehabilitated and/or constructed	Number of health facilities that are rehabilitated and/or constructed (cumulative).	Annual	Project report	Reception reports	PIG
Number of new classrooms created through construction or rehabilitation	Number of new KG and ELC classrooms created through construction or rehabilitation (cumulative).	Annual	Project reports	Project reports	PIG
Number of children 3-5 years old receiving preschool programs	Number of children 3-5 years old enrolled in project-supported preschool programs, including KGs, ELCs and CCDGs, in target districts (cumulative).	Annual	EMIS and data collection from CCDGs	Enrollment data is currently collected by EMIS by age and gender; data collection will be set up under the project for CCDGs	EMIS/PIG
Number of girls 3-5 years old receiving preschool programs	Number of girls 3-5 years old enrolled in project-supported preschool programs, including KGs, ELCs and CCDGs, in target districts (cumulative).	Annual	EMIS and data collection from CCDGs	EMIS and data collection from CCDGs	Enrollment data is currently collected by EMIS by age and gender; data collection will be set up under the project for CCDGs
Number of children 6 years old receiving preschool programs	Number of children 6 years old enrolled in project-supported preschool programs, including KGs, ELCs and CCDGs, in target	Annual	EMIS and data collection from CCDGs	Enrollment data is currently collected by EMIS by age and gender; data collection will be set up under the	EMIS/PIG



	districts (cumulative).			project for CCDGs	
Number of girls 6 years old receiving preschool programs	Number of children 6 years old enrolled in project-supported preschool programs, including KGs, ELCs and CCDGs, in target districts (cumulative).	Annual	EMIS and data collection from CCDGs	Enrollment data is currently collected by EMIS by age and gender; data collection will be set up under the project for CCDGs	EMIS/PIG
Number of teachers, facilitators and coaches completed professional training under project	Number of education personnel that complete professional training provided by the project, including teachers, facilitators, and coaches (cumulative).	Annual	Project reports	Training reports provided to MoES/PIG	MoES/PIG
Number of coaching sessions conducted	Number of coaching sessions carried out to support preschool teachers and CCDG facilitators in target districts (annually).	Annual	Project reports		MoES/PIU
Students benefiting from direct interventions to enhance learning		Annual	EMIS and project reports	EMIS collects data on preschool enrollments; the PIG will collect data on CCDG enrollments.	EMIS/PIG
Students benefiting from direct interventions to enhance learning - Female		Annual	EMIS and project reports	EMIS collects data on preschool enrollments; the PIG will collect data on CCDG enrollments.	EMIS/PIG



Percentage of beneficiaries who report that citizen engagement processes are effective	Beneficiary feedback indicator, measured using targeted Mobile Engage survey. Measures whether households have been consulted / involved in supporting ECD plans and services.	Annually	Mobile Engage Survey	Targeted Mobile Engage Survey includes questions to understand level of citizen engagement in project activities.	CSP/PIG
Percent increase of caregivers attending primary health care centers and Community Child Development Group sessions who report improved decision making in the household	Percent increase of caregivers attending primary health care centers and Community Child Development Group sessions who report improved decision making in the household. The baseline will be measured during the first year of project implementation.	Annual	Mobile Engage Survey	Targeted questions in Mobile Engage Survey to measure improvements in women's decision making power in the household.	CSP/PIG
Number of preschool teachers employed in project-supported preschools	Number of preschool teachers employed to work in project-supported preschools (cumulative).	Annual	EMIS	EMIS collects data on teacher numbers	EMIS/PIG
Number of female preschool teachers employed in project-supported preschools	Number of female preschool teachers employed to work in project-supported preschools (cumulative).	Annual	EMIS	EMIS collects data on teacher numbers	EMIS/PIG



Disbursement Linked Indicators Matrix

DLI 1	Adoption of Government decree on the introduction in the State Budget of program-based budgeting for district and urban primary health care facilities			
Type of DLI	Scalability	Unit of Measure	Total Allocated Amount (USD)	As % of Total Financing Amount
Output	No	Text	1,000,000.00	1.37
Period	Value		Allocated Amount (USD)	Formula
Baseline	0.00			
July 2020 - June 2021	Government decree on the introduction of the principles of the program-based budgeting during preparation of the State Budget in Republic of Tajikistan includes the introduction of program-based budgeting in district and urban primary health care facilities.		1,000,000.00	N/A
July 2021 - June 2022			0.00	
July 2022 - June 2023			0.00	
July 2023 - June 2024			0.00	
July 2024 - June 2025			0.00	



DLI 2	The Minister of Finance Order No. 173 dated January 26, 2015 on "Economic classification of budget revenues and expenditures of the Republic of Tajikistan" is revised.			
Type of DLI	Scalability	Unit of Measure	Total Allocated Amount (USD)	As % of Total Financing Amount
Output	No	Text	1,000,000.00	1.37
Period	Value		Allocated Amount (USD)	Formula
Baseline	0.00			
July 2020 - June 2021	The Minister of Finance Order 173 from January 26, 2015 entitled "Economic classification of budget revenues and expenditures of the Republic of Tajikistan" is revised so that (a) the functional classification category 052 and its subcategory 05201 includes the basic package of outpatient services primary health facilities offer (including primary medical care, provision of medicines, and provision of laboratory tests); (b) the functional classification subcategory 05204 concerning health houses is removed; and (c) expenditure category used for recording of the expenditure in primary health care facilities includes the full package of services provided by those facilities (salaries, medicines, utilities, and other expenses).		1,000,000.00	N/A
July 2021 - June 2022			0.00	
July 2022 - June 2023			0.00	
July 2023 - June 2024			0.00	



July 2024 - June 2025			0.00	
DLI 3	Percentage of district and urban primary health care facilities funded through a separate functional classification			
Type of DLI	Scalability	Unit of Measure	Total Allocated Amount (USD)	As % of Total Financing Amount
Output	Yes	Text	1,000,000.00	1.37
Period	Value		Allocated Amount (USD)	Formula
Baseline	0% of district and urban primary health care facilities are funded through a separate functional classification			
July 2020 - June 2021			0.00	
July 2021 - June 2022			0.00	
July 2022 - June 2023			0.00	
July 2023 - June 2024	44% of district and urban primary health care facilities are funded through a separate functional classification		500,000.00	N/A
July 2024 - June 2025	88% of district and urban primary health care facilities are funded through a separate functional classification		500,000.00	From the baseline of 44%, for each incremental percentage in

**Verification Protocol Table: Disbursement Linked Indicators**

DLI 1	Adoption of Government decree on the introduction in the State Budget of program-based budgeting for district and urban primary health care facilities
Description	Government Decree on the introduction of the principles of the program-based budgeting during preparation of the State Budget in the Republic of Tajikistan includes the introduction of program-based budgeting in district and urban primary health care facilities.
Data source/ Agency	A copy of signed official Decree by the Government of Tajikistan
Verification Entity	WB
Procedure	MOF sends relevant Gazette to WB, WB verifies government decree and approves disbursement.
DLI 2	The Minister of Finance Order No. 173 dated January 26, 2015 on "Economic classification of budget revenues and expenditures of the Republic of Tajikistan" is revised.
Description	The Minister of Finance order 173 from January 26, 2015 entitled "Economic classification of budget revenues and expenditures of the Republic of Tajikistan" is revised so that (a) the functional classification category 052 and its subcategory 05201 includes the Basic Package of outpatient services primary health facilities offer (including primary medical care, provision of medicines, and provision of laboratory tests); (b) the functional classification subcategory 05204 concerning health houses is removed; and (c) expenditure category used for recording of the expenditure in primary health care facilities includes the full package of services provided by those facilities (salaries, medicines, utilities, and other expenses).
Data source/ Agency	A Copy of the Letter from MOF to the Provincial Local Executive Body of State Power with a copy of revised "Economic classification of budget revenues and expenditures of the Republic of Tajikistan"
Verification Entity	WB
Procedure	This could be done either by adding a new expenditure category (e.g. "primary health care service financing") or by amending the description of the current category 221 "purchasing goods and services" to include salaries, medicines, utilities, and other expenses in primary health care facilities. MOF sends relevant Gazette to WB, WB verifies revisions and approves disbursement.



DLI 3	Percentage of district and urban primary health care facilities funded through a separate functional classification
Description	Percentage of district and urban primary health care facilities funded through a separate functional classification
Data source/ Agency	Screenshot of budget submission in MOF financial management software for each provincial local executive body of state power, officially confirmed by MOF
Verification Entity	WB
Procedure	MOHSP



ANNEX 1: IMPLEMENTATION ARRANGEMENTS AND SUPPORT PLAN

Context

1. **Successful implementation of the project requires multisectoral coordination in planning, service delivery, financing, monitoring and policy decision making, involving the Ministries of Finance, Education, Health and Social Protection, Labor and others.** Official documents largely define ECD as equivalent to preschool education. Currently, there is no single state agency that has a mandate for ECD, and two ministries, MoES and MoHSP are undertaking the main tasks that would come under the ECD subsector. However, gaps and overlaps are found in each ministry's tasks regarding ECD as their operation lacks coordination. There are no systematic linkages between the MoES and the Ministry of Health and Social Protection (MoHSP), either at the central or the local level to engage collectively, although both ministries have potentially overlapping mandates to improve ECD outcomes of the 0-6 year age group. The MoES has the mandate for children from 1.5 to 7 years old, and MoHSP has the mandate for families and children from preconception for the rest of their lives. Important and mutually relevant child development related policies and standards are neither developed nor systematically adopted by the two key line ministries; for example, early learning and development standards have been developed by the MoES for 0-7 year old children, but these are not adopted by MoHSP. Data inconsistency exists between MoES and MoHSP in areas such as children with disabilities. In operations, staffing or staff capacity is not based on a harmonized approach. Preschool teachers have limited or no knowledge or skills on health and nutrition related issues for young children, while health workers at PHCCs have little knowledge and skills to help parents practice child stimulation at home. Several relevant projects (water, social protection, etc.) are being supported by development partners; however, there is not yet a clear cross-ministry approach to ensure coordination across all these interventions and policies to enable ECD impact. State funding available for implementation of ECD services is scarce. Thus, the vast majority of existing ECD services, such as immunization, provision of micronutrients and nutrition, are dependent on external support. In the last couple of years, although the government has substantially increased funding for the preschool subsector, this is not nearly enough to maintain current enrollment rates, given the high demand and high birth rate in the country.

2. **To provide a holistic set of services through the project, keeping the child as the focus of interventions will require a change in the mindset and strong coordination mechanisms across the various service providers.** The project will also require considerable support and commitment from high level policy makers in the government, intensive capacity building, for both the implementing agencies at all levels, and frontline human resources, especially in the education sector (preschool teachers of ELCs are to be paid for by the government), to be effective in achieving the project's expected outcomes. Therefore, design and implementation of the project cannot be business as usual and will demand a strong coordination mechanism across the relevant sectors to ensure project success.

At the central level

3. **Establishment of the NECDC.** Given the multisectoral nature of the interventions, by effectiveness the GoT will establish the NECDC **chaired by the Deputy Prime Minister for Social Issues. The Minister of Finance will be the deputy chair of the Council**, which will include the Project Director, representatives of all concerned ministries, such as MoES, MoHSP and others (Labor, Agriculture, Water, etc.), the Executive Office of the President (EOP), and the **Project Coordinator**, who will be the Secretary for the NECDC. The NECDC is the highest level which will review the ECD policy documents prepared by the project before submitting to the Government for final approval. The NECDC is the venue to



convene various ministries and agencies involved in ECD service delivery to: (a) guide ECD policies; (b) provide strategic orientation of medium- and long-term ECD plans in line with the country's development objectives; and (c) review project implementation and provide oversight and support to resolve bottlenecks as required for smooth implementation of the project. The NECDC will be supported by the PIG (see below for more detail) and can call for support from this consultation group, which comprises international and local partners and technical experts to contribute to ECD policy decisions.

4. **The MoF will hold the responsibility for project implementation.** The MoF is the GoT's focal point for the World Bank's Human Capital Project. As project implementation requires multisectoral involvement, the MoF is a key player that can bring together all concerned ministries and agencies to deliver the results of the program in their capacity as the project implementing agency. The MoF will be responsible for overall implementation, coordination, results monitoring, and communicating with the Bank for implementation of all project-related activities. Thus, all project activities will be led by the MoF with support from MoES and MoHSP. The **Minister of Finance will act as Deputy Chair of the NECDC** and will appoint a **Deputy Minister, responsible for investment policy, to be the Project Director** to lead project implementation and monitoring. The MoF will hire the PISP, including consultants to be housed in the PIG who will provide technical and operational assistance for project implementation. In particular, the MoF, in coordination with the MoES and MoHSP, will be in charge of:

- Project management, implementation, monitoring, reporting and evaluation;
- Project Fiduciary responsibilities;
- Coordination of planning, implementation and monitoring across MoHSP, MoES, MoF and districts;
- Coordination of implementation of ECD project activities with key stakeholders (education, health, social protection, water, agriculture, etc.) and facilitate consensus-building among them if required, to ensure a whole of government approach in delivering ECD services;
- Ensuring proper coordination of the project activities with potential investments from other donors in the field of ECD;
- Implementing the ESF, with support from the MoES and the MoHSP;
- Preparing implementation reports for the NECDC;
- Establishing a committee to review and approve District ECD plans – ECD Plans Approval Committee. That committee will comprise deputy ministers of MoF, MoHSP and MoES responsible for the project, and related ministries and PIG staff; and
- Organizing various implementation support visits, a mid-term review, and a final review of the project.

5. **A PIG will be established at the central level under the MoF.** The PIG's vital roles are to provide technical and operational assistance in implementing the project activities at all levels (MoF, MoES, MoHSP and project targeted districts), including FM, procurement, and environmental and social risk management. The **Project Director** will provide oversight to the project to ensure its timely implementation and achievement of results. The Project Director will be able to delegate signatory authority to an Executive Director to speed implementation in the event the Project Director is unavailable. A **Project Coordinator** will be hired by the MoF, to lead the PIG, based on terms of reference acceptable to the Bank, in order to lead project implementation and monitoring. The Project Coordinator will work closely with the **two Deputy Coordinators**, recruited by the MoF from the health and education sectors. These Deputy Coordinators will liaise closely with management and all relevant departments of MoES and MoHSP to: (a) ensure alignment of planning, budgeting, implementation and monitoring; (b) prepare technical proposals and provide technical oversight to the project activities for institutionalization and sustainability of project-supported activities; and (c) support implementation



of selected project activities. The PIG is a group of international and local consultants and specialists with different technical areas of expertise required for project management and implementation. **District Coordinators** under the PIG, located in each target district, are to provide technical and operational support and ensure smooth coordination, implementation and supervision at the district and *mahalla* levels. Other personnel in the areas of procurement, FM, environmental and social risk management, and an M&E team will be hired for the PIG. An international advisor/consultant is also expected to be recruited to support the project management team, as required. The PIG will assist the MoF in implementation, management, supervision and M&E of the project and focus on:

- facilitating the efficiency and effectiveness to deliver project activities and achieve the project's expected outcomes;
- ensuring smooth project implementation in all areas (e.g., policy, financing, and sustainability);
- preparing and ensuring quality of all required documents, reports (implementation, procurement and finance), withdrawal applications, etc. for the Project Director's review and clearance;
- facilitating coordination of project implementation with key stakeholders (education, health and social protection, labor, water, agriculture, etc.) and facilitate consensus-building among them if required, to ensure a whole of government approach in delivering ECD services; and
- ensuring proper coordination of project activities with investments from other donors in the field of ECD.

6. **The MoES and MoHSP play major roles in implementing the project activities, in coordination with the district level, under the leadership of the MoF.** Close collaboration between the two line ministries will be required to ensure harmonized implementation, efficiency of resources, avoidance of overlaps, and creation of a new integrated approach to providing services for the benefit of children. Specifically, the MoES and MoHSP will:

- (a) appoint a **Deputy Minister(s)** responsible for ECD issues to lead the ministerial Technical Team;
- (b) establish a **Technical Team** within the ministry comprising experts in all technical areas related to the project interventions to work closely with the Project Deputy Coordinator in planning, implementing and monitoring project activities;
- (c) ensure that the ministry's **Technical Team** works closely with the **Project Deputy Coordinator**, with assistance from other PIG staff, in: (i) developing Terms of Reference for all sector-specific TA required for project implementation, together with the PIG; (ii) preparing technical aspects of procurement documents; (iii) reviewing and approving technical documents prepared by the consultants/ contractors/suppliers; (iv) contributing to the review of District ECD plans under the guidance of the Project Coordinator; (v) preparing, together with the PIG under the MoF's coordination, all regulatory reform proposals to be reviewed by the NECDC; and (vi) participating in all activities related to project implementation and M&E that are mobilized by the MoF/PIG.

At the district and Mahalla level

7. **The project will be implemented in 14 targeted districts with the lowest preschool enrollment rates and high birth rates.** In each target district, the local government authority will establish a project **DCC** to coordinate, facilitate and monitor implementation of project activities in their district. The DCC will be headed by a Deputy Chair of the local government authority, and comprise key departments related to ECD: finance, health, education, social protection, external communications, WASH and construction. The DCC will be supported by a **District Coordinator** hired by the MoF/PIG and located in the district. Similar to the central level, officials in charge of ECD at the district level will be in charge of project implementation, with support from TA hired by the PIG. Specifically, the DCC will, but not exclusively:



- Lead development of district ECD costed plans based on evidence and data gathered at the community-level, with a breakdown by year, defining expected targets to be achieved;
- Monitor and support implementation of the ECD plan at the community level, including conducting regular monitoring of the implementation of works within the district;
- Encourage families to participate in the new services (especially CCDGs);
- Recruit teachers for new KGs and ELCs, if needed;
- Report to MoF/PIG to seek advice on issues arising in a timely manner;
- Lead outreach and awareness-raising at the *jamoat*- and district-levels on ECD project-planned activities;
- Arrange public consultations on environmental and social instruments;
- Screen ECD plan subprojects for environmental and social risks;
- Implement E&S instruments to avoid, minimize and mitigate environmental and social risks; and
- Establish a Grievance Redress Management group at the district level to receive and action complaints related to project activities.

8. **Mahalla level.** Most of the project activities and inputs for achieving the BP's expected outputs will be implemented at the *Mahalla* level. Therefore, the communities are expected to play a critical role in identifying their needs, setting priorities and contributing to developing the district ECD plan to achieve the BP. **Mahalla Committees** will support implementation, with strong support from the *Jamoat*. Specifically, the *Mahalla Committee* will be responsible for:

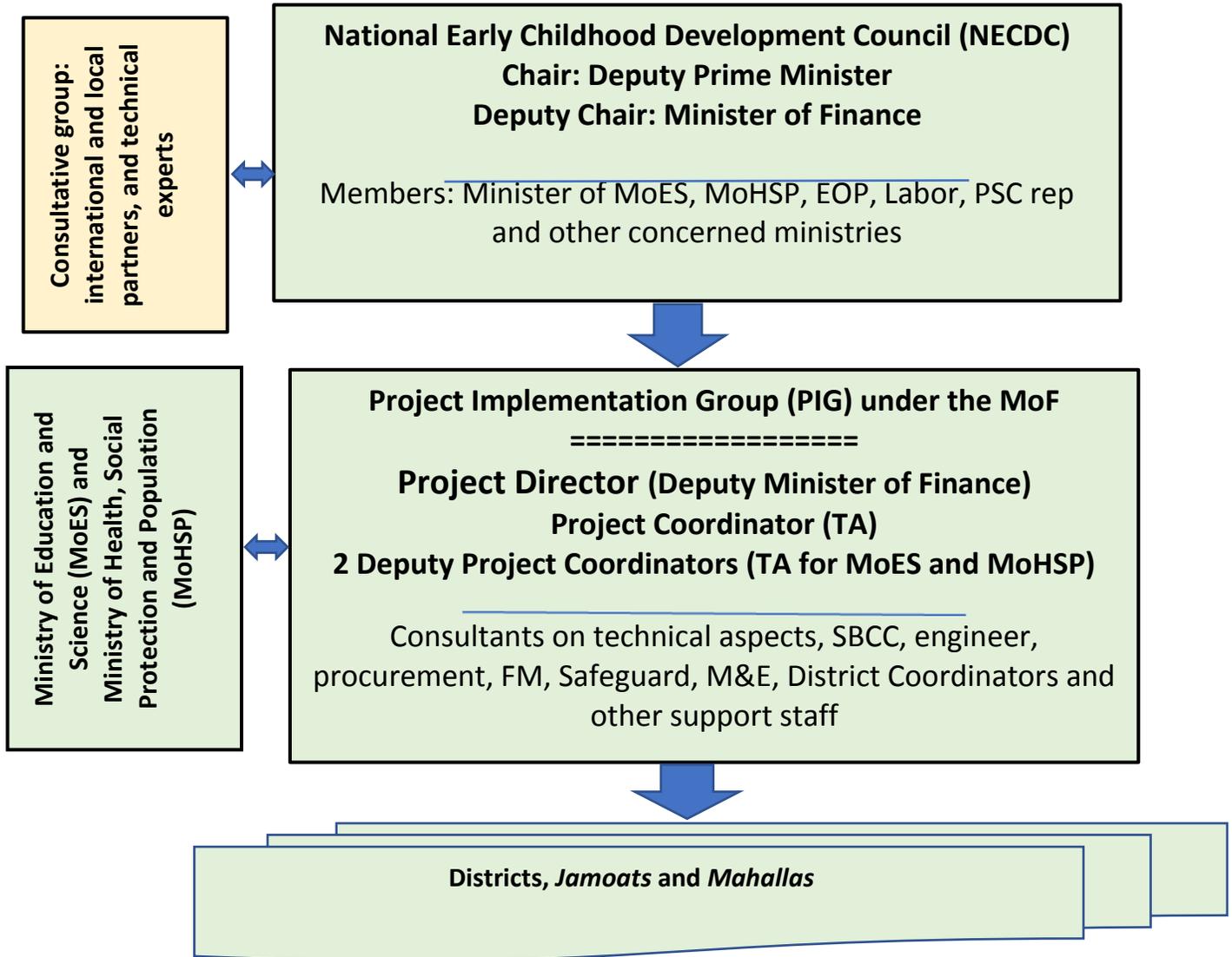
- Identifying needs for achieving the BP for ECD in the community;
- Prioritizing interventions based on budget available to feed into the district ECD plan;
- Mobilizing community members, including identifying volunteer **facilitators for CCDGs**, and ensuring readiness for implementation (e.g., secure venues for new KGs, ELCs and CCDGs, as needed);
- Implementing the project activities laid out in the approved, costed district ECD plan for achieving the BP;
- Encouraging families to be engaged in the project interventions for the benefit of children, including participation in new services (e.g., CCDGs);
- Supervising and providing support as needed in a timely manner;
- Reporting to DCC to seek advice as issues arise;
- Undertaking outreach and awareness raising at the *mahalla* level on ECD project planned activities; and
- Monitoring of implementation of environmental and social instruments.

9. Detailed implementation arrangements will be described in the **Project Operations Manual**, which will be completed as a condition of project effectiveness.

10. The project governance structure is presented in Figure A1.1.



FIGURE A1.1. THE PROJECT GOVERNANCE STRUCTURE





Implementation Support Plan

11. To support the Government in implementation of this multisectoral project, the Bank will provide support through periodic visits complemented by regular correspondence, audio and video connections with relevant counterparts. While MoHSP and MoES have experience implementing World Bank projects, there is little experience within the government in implementing multisectoral projects, and MoF has limited capacity in carrying out the fiduciary roles of an implementing agency. In addition, implementation of the ESF is new to the country. Therefore, it is anticipated that increased support will be needed during the first few years of project implementation.

TABLE A1.1: IMPLEMENTATION SUPPORT PLAN

Period	Focus	Skills needed	Staff weeks (annual)
First 12 months	Implementation support coordination	Task Team Leaders	12
	Overall technical support (health)	Health Specialist	8
	Overall technical support (education)	Education Specialist	8
	Overall Operations support	Operations Officers	12
	FM support and assessments	FM Specialist	2
	Procurement support and assessments	Procurement Specialist	2
	Environmental and Social Risk Management support and assessments	Environmental and Social Specialists	4
	Communications support	Communications Specialist	4
	Technical support (civil works)	Architect (international)	2
	Technical support (civil works)	Engineer (local)	2
13-48 months	Implementation support coordination	Task Team Leaders	6
	Overall technical support (health)	Health Specialist	5
	Overall technical support (education)	Education Specialist	5
	Overall Operations support	Operations Officers	8
	FM support and assessments	FM Specialist	2
	Procurement support and assessments	Procurement Specialist	2
	Environmental and Social Risk Management support and assessments	Environmental and Social Specialists	4
	Communications support	Communications Specialist	2
	Technical support (civil works)	Architect (international)	4
	Technical support (civil works)	Engineer (local)	8
	Third Party Validation	Team (Engineer, Finance)	8
49-72 months	Implementation support coordination	Task Team Leaders	6
	Overall technical support (health)	Health Specialist	3
	Overall technical support (education)	Education Specialist	3
	Overall Operations support	Operations Officers	6
	FM support and assessments	FM Specialist	1
	Procurement support and assessments	Procurement Specialist	1



	Environmental and Social Risk Management support and assessments	Environmental and Social Specialists	2
	Communications support	Communications Specialist	1
	Technical support (civil works)	Architect (international)	4
	Technical support (civil works)	Engineer (local)	8
	Third Party Validation	Team (Engineer, Finance)	8



ANNEX 2: DEFINITION OF THE BASIC PACKAGE OF ECD SERVICES

1. The Bank and the GoT are committed to stay engaged in the long-term to support improved ECD outcomes in the country, and it was agreed that this project would help set the foundations for coordinated development partner support in this important subsector. Therefore, the design of this project aims to have a systematic impact across the country, while noting that regional needs will differ, with the expectation of creating a platform to build up the diversity of services and range of interventions in any subsequent projects. Given the huge challenges in the subsector that the GoT is dealing with, the project would aim to focus on addressing the most pressing issues of ECD while building a strong foundation of the regulatory framework for a multisectoral coordination mechanism, including financing and enhancing the institutional capacity to sustain and continue development for the longer term. The proposed BP aims to ensure: (a) that each child’s growth and development is monitored systematically across the country; and (b) that children in targeted districts enjoy quality services promoting improved ECD outcomes at an essential level. The BP should be seen as a first step in achieving the much more ambitious standards of services promoting improved ECD outcomes in the future and include: (a) what is most essential for the beneficiary population; (b) affordable for the government over the long-term; (c) feasible for implementation within an extremely weak capacity environment; and (d) dynamic so as to include changes over time along the country and sector development trajectory. Support will be provided to local level administrations to improve planning, management and monitoring capabilities, to develop and implement their ECD plan to meet the outputs of the BP.

2. A well implemented and comprehensive BP would expectedly lead to the following results: improved prenatal care, a standardized CGDM Program, a system to provide additional home visits at the primary health care level for children with developmental delays, and increased access to quality preschool education. The elements of a BP are listed below and reflect the activities that are relevant to a BP for Tajikistan, based on reviews of international good practice and extensive discussions within Tajikistan with relevant stakeholders from across government, development partners and beneficiaries.

Expected outputs

Pregnant women have access to prenatal care (including laboratory test and parenting contents) at least four times during pregnancy
Children aged 0 to 3 registered with and complete a standardized CGDM Program with at least 14 checkups between 0 to 3 years of age within a PHC setting (these checkups with a healthcare worker provide parenting supporting, growth and development monitoring, vaccinations, promotion of early child stimulation, and other preventive health interventions)
Children with developmental delays receive additional home visits from PHC nurses, additional support for child stimulation, and referrals for secondary services when needed
Participation in preschool for 3 to6 year old children (target areas): Children age 3 to5 to attend CDGs (in case there is no space available in ELCs and KGs). The minimum attendance is two sessions per week and two hours per session (minimum of four hours total per week) Children age 6 and above in targeted areas to attend one full year of quality school preparedness activities, either through KG or ELC



Health and nutritional services (i.e., immunization program, screening of child diseases, prescription of vitamins, and nutrition supplements, deworming treatments, etc.)
Gender equity is achieved in preschool enrollments
Children with disabilities are identified early and enrolled in appropriate rehabilitation services, with the aim of pre-schooling and school mainstreaming
Society, leaders, communities have a better understanding of the importance of ECD

3. To support progress towards the BP as defined above, the World Bank will support financing of the following activities:

Expected Inputs

Input	Proposed coverage
A. National and targeted SBCC and parenting engagement	National
B. Care through primary health care services, home-based care and stimulation (pre conception to 3 years)	National
<ul style="list-style-type: none"> Provision of equipment and training to support pregnant women having access to prenatal care (including laboratory test and parenting information) at least four times during pregnancy 	National
<ul style="list-style-type: none"> Design and development of a CGDM Program with at least 14 checkups between ages 0 to 3 within a PHC setting (these checkups with a healthcare worker provide parenting supporting, growth and development monitoring, vaccinations, promotion of early child stimulation and other preventive health interventions) 	National
<ul style="list-style-type: none"> Equipment and training to increase the number of children receiving access to a Standardized CGDM Program, including printed materials and basic equipment to implement the new CGDM Program 	National
<ul style="list-style-type: none"> Training to increase in the number of health workers able to implement the new CGDM Program with special focus on parenting and early stimulation 	National
<ul style="list-style-type: none"> Provision of equipment and training to support treatment pathways for children with developmental delays, so that they can receive additional home visits from PHC nurses, additional support for child stimulation and referrals for secondary services when needed 	National
<ul style="list-style-type: none"> Training to support an increase in the number of PHC nurses conducting regular household visits (frequency based on risk factors) 	National
<ul style="list-style-type: none"> Provision of equipment, construction support and materials to increase the number of children receiving health and nutritional services (for example, immunization program, screening of child diseases, prescription of vitamins, and nutrition supplements, deworming treatments, etc.) 	National
<ul style="list-style-type: none"> Civil works to support an increase in the number of primary healthcare facilities with solid construction, access to safe water and sanitation, medical and non-medical equipment, enough space for implementing CGDM Program, and child development rooms. This will primarily be rehabilitation and, in selected cases, a small number of new constructions 	Targeted



Input	Proposed coverage
<ul style="list-style-type: none"> ▪ Provision of equipment and training to increase capacity to support referrals to secondary care for children with developmental delays 	Targeted
<ul style="list-style-type: none"> ▪ Supervision of CGDM Program implementation 	Targeted
<ul style="list-style-type: none"> ▪ Rehabilitation and construction to support increased access to early child stimulation rooms with enough educational toys (toy libraries) to support child stimulation activities for a local community 	Targeted
C. CCDGs, center-based care and learning (3-6 years)	
1. Preschool teachers:	Targeted
<ul style="list-style-type: none"> ▪ As per Government policy, teachers have at minimum, secondary or higher professional pedagogical education 	
<ul style="list-style-type: none"> ▪ Teachers receive professional training on instructional methods relevant for age group and to facilitate learning by playing 	
<ul style="list-style-type: none"> ▪ Teachers receive regular support for continuous professional development through coaching at KG and ELC 	
2. CCDG facilitators:	Targeted
<ul style="list-style-type: none"> ▪ Facilitators are working on a volunteer basis and selected by the community, based on terms of reference for the position 	
<ul style="list-style-type: none"> ▪ Facilitators receive training on organizing and facilitating play activities for multi-age groups, in coordination with caregivers 	
<ul style="list-style-type: none"> ▪ Facilitators receive regular mentoring support from coach 	
3. Educational toys and materials for improved quality of early learning:	Targeted
<ul style="list-style-type: none"> ▪ Enough educational toys appropriate for each age group provided to each KG classroom, and ELC to support playing activities 	
<ul style="list-style-type: none"> ▪ At least a children books corner (with about 10 titles) appropriate for different age groups provided to each KG classroom, ELC and CCDG 	
<ul style="list-style-type: none"> ▪ All children are equipped with enough (minimum) consumable materials for learning activities through playing 	
4. KG and ELC infrastructure	Targeted
<ul style="list-style-type: none"> ▪ KGs and ELCs premises to have solid construction (walls, floors and roofs), compliant with fire, seismic and ecological norms, including sanitary and lighting aspects 	
<ul style="list-style-type: none"> ▪ Each KG classroom and ELC should have a set of furniture (writing board, enough tables and chairs for kids, shelves) and TLMs to enable a quality learning process 	



ANNEX 3: DETAILED PROJECT DESCRIPTION

1. **The project introduces the BP of services to promote improved ECD outcomes through four components.** Components 1 and 2 focus on national level interventions, Component 3 focuses on targeted district level interventions, while Component 4 supports project management and coordination. The BP under the project aims to ensure that: (a) each child's growth and development is monitored systematically across the country; and (b) children in targeted districts enjoy quality services that promote improved ECD outcomes at an essential level. A list of 14 districts for Component 3 interventions have been determined based on transparent criteria with the overall goal of reaching the most disadvantaged households and communities in the country. The final criterion established by the Government was to select districts based on the lowest preschool enrollment rates (below 6.75 percent as of October 2019) in the country and high birth rates. This list of districts is consistent with the proposed list determined through a multi-dimensional children's needs index developed for the purpose of determining the target areas for this project. Most of these areas also overlap with the GPE/IsDB Basic Education Project, which is responsible for constructing 68 schools with one classroom dedicated to run an ELC, and the World Bank-supervised CSP and SERSP, and therefore could benefit from synergies in several areas related to provision of services promoting improved ECD outcomes and community participation. Proposed activities for potential follow-on investments are included in Box A3.1.

BOX A3.1: PROPOSED ACTIVITIES FOR POTENTIAL FOLLOW ON INVESTMENTS THAT ARE NOT INCLUDED IN THE PROJECT

Phase 2

- Further strengthening of the regulatory environment supporting multisectoral provision of services to promote improved ECD outcomes, such as:
 - Incorporating evidence from project 1 into government's policy and programming
 - Including alternative models of ECEC in government policy
 - Improving ECD data sharing and collaboration between key agencies
 - Assisting government to integrate other efforts to ensure all children and families have access to the BP, such as through the TSA, nutritional interventions (micronutrients, food fortification).
- Expand definition of BP to include:
 - Expanding CGDM Program to cover 3-6 year-old
 - Further support to prenatal care, including expansion of screening for congenital disorders
 - Strengthen secondary diagnosis, treatment, including medical equipment and training to support and expand pediatric cognitive and neuromotor evaluation and speech therapy at Regional level
 - Strengthen rehabilitation (motor, cognitive, sensory, language) services for children 0 to 6 year-old, including support to rehabilitation Centers at National and Regional level
 - Further increase in access to preschool services
 - Improve capacity of preschools to provide inclusive opportunities for children with all levels of need
- Scale up successful interventions under the BP to more districts
- Continue national and targeted SBCC campaigns, which require long-term and sustained efforts to make an impact on perceptions and behaviors
- Increased geographical coverage of the BP

Phase 3

- Incorporate lessons learned from previous two projects to the BP in preparation for mass expansion.



- Mass expansion of the BP to support government's efforts, including:
 - Strengthening the PHC capacity and conditions to implement the CGDM Program in other districts.
 - Expanding the number of districts with rehabilitated PHCCs that include ECD rooms
 - Supporting government to meet targets on preprimary enrollment and improving quality
- Expand secondary diagnosis and treatment at district level, including:
 - Implementation of multidisciplinary groups for case management of children with additional/special needs
 - Implementation of community-based rehabilitation at district level supported by the multidisciplinary groups
- Development of an information system to monitor children with special needs, or expand existing sectoral information systems so that children with additional needs can be tracked nationally and across sectors
- Continue national and targeted SBCC campaigns, which require long-term and sustained efforts to make an impact on perceptions and behaviors

Component 1: Strengthening capacity to deliver the Basic Package of Early Childhood Development services (IDA: US\$1.8 million; GFF: US\$3.0 million)

2. The objective of this component is to strengthen capacity to deliver a Basic Package of services that promote improved ECD outcomes, as defined in Annex 2. There are five sub-components aimed at supporting this objective.

3. *Sub-component 1.1: Update and development of the guidelines, programs, materials and resources for implementation of a BP of services for improved ECD outcomes.* The objective of this sub-component is to update and develop the resources needed to support implementation of the BP at national and district levels. Activities financed by the project will include TA for: (a) development of a BP Manual; (b) integrating and streamlining prenatal care guidelines and tools; (c) updating the CGDM Program; (d) review and adaptation of curricula, equipment and TLMs for existing and alternative preschool models; and (e) revising designs of preschool constructions. Activities under this sub-component will all begin during the first year of project implementation.

(a) **Development of a BP Manual.** A BP Manual will be developed to provide clear guidance to enable multisectoral planning and implementation of the BP at the district and community level. It will guide all implementers (district administration staff, and staff of PHC facilities and preschools) on how they work together to serve children in their communities to enhance ECD outcomes. It will include: a detailed definition of the BP; a planning tool to enable local administrations and communities to develop their plans to support implementation of the BP; relevant sections of the CGDM Program manual; guidance on the set up and operation of existing and alternative preschool models, training materials for joint training of health and education staff and guidance on the use of district funds. The BP Manual will include detailed information to guide the whole project implementation process at the community level, activity by activity, and answer questions such as what activity and how the activity will be implemented, by whom and when, and also how to measure the outputs or outcomes.

(b) **Update and standardize prenatal care guidelines.** The prenatal care program will be streamlined to include clinical guidelines for health workers,⁵¹ as well as incorporate and strengthen content on parenting awareness and skills, with a focus on ECD and early child stimulation. The guidelines will also include screening and pathways for referrals to secondary care, and promotion of family planning. The project will support an

⁵¹ The new/updated guidelines will include updates to the ambulatory card that will include a risk score and an algorithm to strengthen the quality of each prenatal care checkup and clearly define when referrals (for secondary care) are needed.



update of the ambulatory cards to be used in PHC services, handbooks for pregnant women and referral forms. Revision of the guideline will be led by MoHSP, positioning them in the driver's seat for a more sustainable approach.

(c) **Update of the CGDM Program.** This activity will also support the MoHSP to include developmental monitoring (including social, cognitive, language, and motor skills) in child health services, as it is currently not provided. The updated program guidelines will also seek to enhance parental engagement and focus on early child stimulation. This will be facilitated by: the introduction of revised guidelines and tools for CGDM; PHC nurses conducting household visits, with a frequency aligned with children's needs and risks; and, a supervision system to monitor the implementation of the program. Review and revision of existing protocols, curriculums and materials for CGDM will also take place. The program will: standardize the number and timing of regular checkups; update the ambulatory card (a prototype of this has been widely discussed with the government); provide guidance and checklists for health workers to focus on specific topics, such as growth and nutritional status, immunizations and the achievement of specific developmental milestones across four critical domains (motor, cognitive and linguistic skills or socio-emotional development). The updated program will also include a bottom-up monitoring scheme that will, on a monthly basis, collect information from the revised ambulatory cards of children that have reached 6, 12 and 24 months in the previous month to identify children that require additional services (household visits or more frequent checkups) and assess the outcomes of the program at the local level. These three cutting points will allow the following of the different cohort of children and create comparable data to analyze the trends on the different indicators measured by the CGDM Program. This will also enable local health workers to provide additional services to children at risk of not reaching specific milestones and report progress and outcomes of the program to higher authorities. Aggregated information from each PHC center will be reported to the districts, regional and national level, creating a monthly reporting system on the progress of the program and the status of children included in the program that will contribute to the decision-making process.

(d) **Review and adaptation of curricula, equipment specifications, and teaching and learning materials for existing and alternative preschool models.** The MoES is in the process of reviewing TLMs for KG and ELC which is expected to be ready by March 2020. In order to support rapid expansion of access to preschools, existing curricula and resources for KGs and ELCs will be used and reproduced for new classroom spaces supported by the project in the early years. Based on the project experience, the materials will be reviewed and adapted later in the project for the national scale up (undertaken by the government after the project completion with possible support from another Bank-supported project and/or support from other development partners). Modern preschool teaching approaches like "open space" and "environment as the third teacher" concepts will be reflected in the revised, gender sensitive and inclusive curriculum too. Further expansion in access to preschool services will be provided through the establishment and operation of CCDGs in targeted districts under sub-component 3.2. Although this model is not currently supported by the GoT there are many good resources and practices available around that world which could easily be contextualized for Tajikistan. TA will be financed to adapt materials, resources for CCDGs in the first year of project implementation. This activity will be led by MoES.

(e) **Review and Redesign of preschool constructions.** The project will finance TA for the review of existing KG and ELC designs to accommodate the modern teaching approaches mentioned above, and existing building codes. Based on the review, revisions will be made to these existing designs and building codes to take best practice from international designs, adapted to the Tajik context, and include: access to improved WASH facilities; energy efficient designs (such as through improved lighting, heating, windows and insulation, and



appliances); accessible and inclusive spaces for children with special needs; and quality and safety of infrastructure that are resilient to climate and geophysical hazards. An assessment will be carried out to determine the cost effectiveness of new buildings versus rehabilitation of existing spaces. These designs will inform constructions and rehabilitations of KGs and ELCs in targeted districts under sub-component 3.2.

4. *Sub-component 1.2: Staff training (technical and managerial).* The objective of this sub-component is to strengthen knowledge and capacity of staff (national trainers and administrators/managers) to oversee and implement the BP through training and study visits for these staff. To achieve this, the project will finance, in addition to study visits: (a) development of in-service education and training packages for trainers and staff responsible for oversight of implementation and monitoring of the BP on relevant topics, both in health and education, at the national level; and (b) training of trainers and to managerial staff on the developed packages. The training packages will, inter alia, integrate content on gender targeting and climate change adaptation and mitigation, including energy and water conservation measures that can be taken in the staff workplaces and promoted through their regular work. This activity will be led by the PIG in coordination with the MoES and the MoHSP starting in the first year of implementation and carried out as needed throughout the life of the project.

5. *Sub-component 1.3: Development of a national M&E system on ECD and evaluation of the project interventions.* Under the current regulatory and legal framework, resource allocation and accountability for ECD outcomes is split largely between the MoES and the MoHSP, with multiple overlaps, which inhibits the coordination of services for young children and the targeting of resources to best promote ECD, which requires a multisectoral approach. However, reforming the regulatory and legal framework to consolidate decision making and accountability for ECD is a long-term process and the model of how to do this depends largely on the specific country context. This sub-component aims to: (a) support foundational activities to promote the alignment of government decision making that affect ECD outcomes with accountability for those outcomes; and (b) evaluate project interventions to inform government decisions on scale up. The project will finance: (a) a national assessment of ECD outcomes; and (b) development and implementation of surveys to evaluate the KGs, ELCs and CCDGs supported by the project.

6. **Assessing holistic child development, service quality and citizen engagement.** In order to build the capacity of government to measure outcomes and evaluate investments in the ECD sector, three types of surveys are planned at the beginning and end of the project. These are (a) eHCI; (b) teacher and facilitator observations in ELCs, KGs and CDGs; and (c) a citizen engagement survey (see Table A3.1). Surveys would be conducted at the beginning and end of the project and be national in scope but with the possibility of oversampling in the targeted districts and selected non-targeted, comparison districts.

TABLE A3.1 SUMMARY OF CHILD DEVELOPMENT, SERVICE QUALITY AND CITIZEN ENGAGEMENT SURVEYS

Survey	Outcome / process measures	Sampling	Frequency
1. Child outcomes eHCI	child development, parenting practices, use of services	2 stage: <i>mahallas</i> then households, same <i>mahallas</i> sampled at baseline and end-line, national sample, oversampling in targeted districts and comparison districts	year 2020/21 (baseline) and 2025 (end-line)
2. Service quality			



PHC observations	CGDM practices and practices related to other trainings	1 stage, national sample oversampling in targeted districts and comparison districts	year 2023 (midline) and 2025 (end-line)
KG classroom observations	teaching practices	as above	year 2020/21 (baseline), year 2023 (mid-line) and 2025 (end-line)
ELC classroom observations	teaching practices	as above	Year 2020/21 (baseline), year 2023 (mid-line) and 2025 (end-line)
CCDG observations	facilitator practices	as above	year 2023 (mid-line) and 2025 (end-line)
3. Citizen engagement			
Mobile engage	whether households consulted / involved in supporting ECD plans and services	mobile engage SMS question sent nationally (responses from targeted areas to be compared with data from non-targeted areas)	annual

7. **eHCI:** This is a low-cost rating assessment of child cognitive, socio-emotional and physical development. It was conducted in Tajikistan in 2019 as a household survey in which caregivers provided information about the capabilities and development of their children. The instrument also collects data on parenting practices related to early stimulation as well as information about participation in preschool programs (including ELCs and KGs). The instrument would be modified to provide information about CCDG participation as well as information about frequency of attending CCDGs, ELCs and KGs. Data collection and summary analysis would be conducted by a local firm under the guidance and supervision of international TA. TA will be also provided to the government on the interpretation, meaning and potential policy responses of the findings. The data would also be used as part of the evaluation of project at completion.

8. **PHC staff, teacher and facilitator observations:** observations of PHC staff, ELC and KG teachers and CCDG facilitators will be developed based on the content of the training that staff are receiving and the standards that have been developed for M&E. The instruments for the assessment of training effectiveness will be developed in the first year of the project. Additional modules will be developed to assess the service quality once the standards of service quality are developed. The observations would be sample-based and would be conducted by coaching and mentoring staff and supported by a local firm. A local firm would also be hired to tabulate reports, and TA would be provided to government on the interpretation, meaning and potential policy responses of the findings.

9. **Citizen engagement:** The ongoing monthly household survey, Listening to Tajikistan (L2T), would be leveraged by including additional questions about citizen participation in the targeted districts related to ECD planning, community mobilization activities and services. Additional questions to the survey would be developed in the first year of the project and included in the L2T survey once per year.



10. **Sampling strategy:** All three activities would be sampled in order to be representative (a) nationally; (b) of targeted districts; and (c) to allow comparisons of outcomes between selected targeted and comparison districts. The eHCI would be implemented as a stratified two-stage sample design with *mahallas* being sampled first as the primary sampling unit and households being sampled second as the secondary sampling unit; all eligible children within households would be assessed. The observation tools would be implemented as stratified single stage design with PHC facilities, KGs, ELCs and CCDGs being selected at random. The community engagement survey would follow the L2T survey design. Sample design, including sample size determination and development of the sampling frames would be completed at the beginning of the project. All surveys would be conducted once at baseline and once at end-line, with the exception of the citizen engagement survey which would be conducted more frequently. The eHCI would sample the same *mahallas* at baseline and end-line, while the observation surveys would sample the same centers and CDGs at baseline and end line with additional centers and CDGs included at the end-line to reflect the increase in number of services.

11. *Sub-component 1.4: Supporting financing reforms for enhanced services that promote improved ECD outcomes.* Current financing of PHC in Tajikistan may impede rollout of the CGDM Program. The calculation of budgets for and expenditure of PHC facilities are currently by line items. PHC managers have no flexibility in terms of shifting budgets across budget lines. Unexecuted funds, against any budget line, are reallocated by district finance authorities outside of the health sector at the end of the financial year. By supporting financing reforms that provide greater flexibility to shift funds across budget lines, higher budget execution in PHC will be achieved leading to more funds available for PHC services, particularly to pay the salaries of PHC workers who will be implementing the CGDM Program nationwide.

12. **The GoT is planning to gradually introduce program-based budgeting in the public sector to improve PFM.** The changes in the regulatory framework are planned for the calendar year 2020 and the gradual roll-out is expected to begin in 2021. This general PFM reform creates an opportunity to improve the efficiency and budget execution in PHC in Tajikistan. In order to fully benefit from this opportunity, it is critical that the roll-out of the reforms includes the health sector early on.

13. **To incentivize the inclusion of PHC as one of the areas for the early roll-out of program-based budgeting, this sub-component will introduce three DLIs.** The first two DLIs will provide incentives for the changes in the regulatory framework related to the way budgets for PHC are formulated and the way their execution is recorded. More specifically, the first DLI will be linked to the changes in the government decree on the introduction of the principles of program-based budgeting during preparation of the state budget in Republic of Tajikistan so that it includes the introduction of program-based budgeting in district and urban PHC facilities. The second DLI will be linked to changes in Order 173 of the MoF to revise budget and expenditure (functional and economic) categories that would align the single program budget line for PHC with the package of services those facilities should offer (see Table A3.2 for the full proposed formulation of the DLIs). The first modification is to ensure that the functional classification that will be used as the line for program budgets include all the elements and services of the (basic package) of PHC services, i.e., that it becomes the "PHC" program classification. The second modification is to remove a separate category for the lower level of PHC facilities (health houses), so that budget can be moved between a rural health center and its associated health houses as needed. The final modification is the equivalent of the first, but on the expenditure side, i.e. so that the line/category for recording the expenditure for PHC includes all the key expenses that are needed to provide the basic package of services. Table A3.3 provides suggested wording for the changes under DLI2, however alternative wording that achieves



the same objective would be acceptable. The third DLI will provide incentives for the roll out of program-based budgeting in primary health care facilities in Tajikistan.

14. **Eligible expenditures to be financed under Sub-component 1.4.** Eligible expenditures related to the activities under Sub-component 1.4 (under DLIs disbursement conditions) will be the health workers salaries at PHC facilities together with associated mandatory payments of the employer like social charges. The proposed Eligible Expenditures are justified under the Project PDO and subcomponent 1.4 activities because PHC services will implement nationwide the new CGDM Program critical to achieve the Project PDO and two of the PDO indicators. In addition, subcomponent 1.4 will provide greater flexibility and reliability of funding flows to PHC facilities through supporting higher budget execution thus protecting the availability of human resources. While subcomponents 1.1 and 2.2 will finance investments to update and implement the CGDM Program including update of the CGDM Program guidelines, printed materials, training, equipment and some rehabilitation works, the main cost of implementation of the CGDM Program will be those associated with ensuring the availability of adequate numbers of qualified health workers at PHC facilities.⁵²

⁵² This is in line with the 2018 World Bank Guidance on Investment Project Financing with DLIs.



TABLE A3.2: DETAILED DLI DESCRIPTION

	<i>Total financing allocated to DLI (US\$ million)</i>	<i>Share in total financing amount (percentage)</i>	<i>DLI Baseline</i>	<i>Indicative timeline for DLI achievement</i>					
				<i>Year or Period 1</i>	<i>Year or Period 2</i>	<i>Year or Period 3</i>	<i>Year or Period 4</i>	<i>Year or Period 5</i>	<i>Year or Period 6</i>
DLI 1: Adoption of government decree on the introduction of program-based budgeting in the State Budget, which includes district and urban primary health care facilities.	1	TBD	0						
Allocated amount (US\$ million):				1					
DLI 2: The Minister of Finance Order 173 from January 26, 2015 entitled "Economic classification of budget revenues and expenditures of the Republic of Tajikistan" is revised so that (a) the functional classification category 052 and its subcategory 05201 includes the basic package of outpatient services primary health facilities offer (including primary medical care, provision of medicines, and provision of laboratory tests); (b) the functional classification subcategory 05204 concerning health houses is removed; and (c) expenditure category used	1	TBD	0						



for recording of the expenditure in primary health care facilities includes the full package of services provided by those facilities (salaries, medicines, utilities, and other expenses).									
Allocated amount (US\$ million):				1					

DLI 3: Percentage of district and urban primary health care facilities funded through a separate functional classification.									
DLI 3.1: 44% of district and urban primary health care facilities are funded through a separate functional classification	1	TBD	0	0	0	10	44	88	
DLI 3.2: 88% of district and urban primary health care facilities are funded through a separate functional classification									
Allocated amount (US\$ million):				0	0	0	0.5	0.5	



Table A3.3: DETAILED DESCRIPTION OF DL12 PROPOSED CHANGES

Actual description of the classification	Proposed description of the classification
05201. Health centers (clinics) of a wide profile - Organization of work, management, implementation, provision of medical services provided by health centers (clinics) and general practitioners. Health centers (polyclinics) are considered medical institutions that mainly provide outpatient care to patients. Practitioners treat patients in their offices for consultation, visit patients at home. Like the services of general hospitals, the services of health centers (clinics) are provided by doctors, not limited to certain types of diseases that can be treated. Along with other costs, there are direct payments to patients individually (in accordance with the state health insurance system).	Edit 05201. Health centers (clinics) of a wide profile - Organization of work, management, implementation, provision of medical services provided by health centers (clinics) and general practitioners. Health centers (polyclinics) are considered medical institutions that mainly provide outpatient services to patients, including primary medical care by doctors, prevention of communicable and non-communicable diseases, the provision of medicines and the provision of general laboratory tests. Practitioners treat patients in their offices for consultation, visit patients at home. Like the services of general hospitals, the services of health centers (clinics) are provided by doctors, not limited to certain types of diseases that can be treated. Along with other costs, there are direct payments to patients individually (in accordance with the state health insurance system).
05204. Health Houses - This category covers the provision of medical services (only to nursing staff) providing outpatient care to patients located in remote places (<i>jamoats</i>)	Remove 05204. Health Houses



- Add 2220.** Expenditures of primary health care services (Per capita financing)
- a) the payment of wages at the established official salaries, rates for all full-time employees, as well as for each attached / registered person, b) the payment of allowances and surcharges to wages established for evaluating the performance of employees;
 - c) payment (of awards for length of service and other remuneration established by applicable law;
 - d) payment for overtime work, work on weekends and holidays, being in a barracks position in accordance with applicable law;
 - e) payment of monetary compensation in exchange for unused vacation in the established manner;
 - f) other additional types of cash support established by applicable law (including the payment of lifting allowances for relocation).
 - g) the acquisition of goods to ensure inventory, including medicines, materials for diagnostics
 - h) Acquisition of technical goods
 - i) Combustive-lubricating materials
 - j) Operating expenses other than repairs
 - k) Maintenance
 - l) Payment for specialist services
 - m) Payment for utilities
 - n) Payment for communication services
 - o) the acquisition of other goods and services



15. *Sub-component 1.5: Development of an ECD regulatory framework, including governance, financing mechanism, and staffing.* Currently, resource allocation and accountability for ECD outcomes is split largely between the MoES and the MoHSP, with multiple overlaps, which inhibits the coordination of services for young children and the targeting of resources to best promote improved ECD outcomes. However, revamping the regulatory and legal framework to consolidate decision making and accountability for ECD is a long-term process and the model of how to do this depends largely on the specific country context. This sub-component aims to support the development of a regulatory foundation to (a) create an enabling environment for multisectoral ECD service delivery through a range of service options; (b) identify the relevant stakeholders and their roles and responsibilities for the provision of the various components of ECD services; and (c) establish national integrated ECD leadership and coordinating structure. To achieve this, the project will finance TA to develop governance capacity across education, health and finance and other sectors as required, which includes the regulatory framework, capacity building at the central and decentralized levels for integrated planning, supervision and monitoring of service provision promoting improved ECD outcomes, as well as monitoring ECD outcomes. The development of regulatory framework will be informed by evidence gathered from the evaluation of the project implementation over time.

Component 2: Implementing nationwide selected elements of the Basic Package (IDA: US\$9.2 million)

16. **The objective of this component is to support nationwide implementation of elements of the BP through SBCC and roll out of the CGDM Program.** This will be achieved through two sub-components.

17. *Sub-component 2.1: Social and Behavioral Change Communications.* A comprehensive public awareness campaign and SBCC are essential for reaching the PDOs. A focus on the importance of child development constitutes a significant shift in mindset at different levels of the system: government officials, health and education workers, communities, and families. Therefore, based on a stakeholder analysis, a comprehensive communication strategy with culturally appropriate messages and approaches developed as part of the project will target audiences at various levels to enhance the understanding about the full definition of ECD, including nutrition, responsive care and early stimulation and alternative early learning interventions. The ultimate objective is to influence parental practices in a positive way, help create stronger multisectoral links within institutions at the national and local levels and increase public demand for quality and affordable services that promote improved ECD outcomes. At the national level, a comprehensive communication and advocacy campaign will target policy makers and decision makers, private sector, media, religious leaders and other social influencers (such as Goodwill Ambassadors, local sports champions, etc.) to: increase understanding about the full definition of ECD – prenatal nutrition, social protection, and early stimulation and learning; the importance of intersectoral coordination mechanisms; creation of comprehensive ECD strategies and policies; and increasing investments for quality multisectoral ECD policies and services, including by exploring alternative models of high quality and efficient early childhood education that would work effectively in Tajikistan. A wide range of tools such as television, newspapers, radio and social media campaigns will be utilized to best reach these audiences with messages. The project will finance: (a) TA to carry out the stakeholder analysis, (b) develop the communication strategy and campaign materials; and (c) communications costs associated with implementation of the communications strategy.

18. *Sub-component 2.2: Nationwide implementation of child developmental monitoring.* This sub-component will finance the production and distribution of materials for the implementation of the updated ambulatory card for pregnant women and for the implementation of the updated CGDM Program. The sub-component will finance basic equipment and training to implement the CGDM Program nationwide. Training will be provided at the regional level,



led by the PIG and implemented through the MoHSP, to support nationwide roll out, recognizing that these centers can play a role in a multi-pronged strategy for a cultural shift in the monitoring of child development.

19. Additionally, this component will provide training and the provision of ultrasound and laboratory equipment at regional level to support prenatal care and early detection of intrauterine growth restriction, congenital and genetic defects and other conditions that can affect intrauterine and childhood development. This sub-component will also finance refurbishing works, training and equipment related to pediatric rehabilitation areas in the district PHC centers and other rehabilitation services to support assessment, treatment and rehabilitation of children referred from rural PHCCs. Revised CGDM guidelines will prompt earlier identification of more at-risk children in need of specialized services. If needed, small works for rehabilitation of these units would be also supported. These district PHCCs and other rehabilitation services will provide regular specialized services to support children with developmental delay to resolve or minimize the impact of their conditions, such as physiotherapy or speech therapy. Activities will begin in the first/second year of implementation and continue throughout the life of the project.

Component 3: Improving access to the Basic Package in targeted districts (IDA: US\$56.0 million)

20. **The objective of this component is to support local administrations and communities in targeted districts in developing, implementing and monitoring their ECD plans aligned with the goals of the BP.** The objectives of this component will be achieved through four sub-components.

21. *Sub-component 3.1: Development of district ECD plans.* The project will introduce a vital innovation to help target areas develop integrated ECD plans aimed at delivering the BP. Information for the plans will be obtained from communities/*mahallas*, who will need to be mobilized and informed about the BP and supported in determining their needs and to develop an optimal mix of solutions to help achieve the BP in their communities. The project will leverage the models of community mobilization that are expected to be employed under the World Bank-supported SERSP and the CSP. Both projects rely heavily on the *mahalla* level (below the village level) as a locus of community mobilization, planning and implementation of projects (including health, education and social services). The district staff will be expected to work with the line ministries to finalize *mahalla*-level plans for the development of the district-level ECD plan. An estimated budget for achieving the BP expected outputs will be earmarked for each target district to enable the development of a realistic plan. The plan will be developed based on needs assessments made by communities, taking into account other existing and future support during the course of the project life to avoid overlapping and ensure coordination. The plan needs to define the annual target and priority to be achieved that fit with the implementation capacity and budget envelop provided. The project will finance: (a) training for district staff in planning, implementation and monitoring implementation progress of the BP; (b) TA to develop ECD plans to achieve the BP in target areas; and (c) a targeted SBCC campaign at the local level, which will aim to assess ECD needs, support identification of activates to be included in the integrated ECD plans, and enhance family and community support for early childhood stimulation and development, improve parental practices, and empower health workers and educators to support parents and provide quality services that promote improved ECD outcomes at the local level.

22. *Sub-component 3.2: Implementation of district ECD plans.* The objective of this sub-component is to support local administrations and communities in targeted districts in the implementation of their district ECD plans developed under sub-component 3.1. Activities will focus on rehabilitation and provision of equipment, supplies and training for selected PHC facilities, increasing support to nurses implementing the CGDM Program, and expansion in access to preschool



education. Districts will be supported in the implementation of the District ECD plan (including financing of monitoring, supervision, specific campaigns and petty cash for CCDGs and KGs. Travel costs for teachers/facilitator training will be managed by the Institute for Professional Development. The following paragraphs provide an overview of what the District ECD Plan may include for different age groups.

For 0-3 year olds

23. **Rehabilitation and construction, provision of equipment and supplies and training for PHC facilities.** PHC facilities will be rehabilitated to improve access to water and sanitation, quality and safety of existing infrastructure that are resilient to climate and geophysical hazards, cost effective, safe, and energy efficient, such as through improved lighting, heating, windows and insulation, and appliances, and create ECD service rooms and settings for ECD programming. Many PHC facilities require rehabilitation and in a small number of selected cases, construction of new facilities may be needed and supported. Addressing this need will help to build the ability of PHCPHC to support provision of the Basic Package of ECD Services by providing safer, sanitary forums for PHC workers to deliver the updated CGDM Program. Child development rooms will be part of PHC rehabilitation (through designating existing spaces for this purpose or adding additional rooms, where possible). These will provide health workers and parents with a dedicated space, and materials, to implement the CGDM Program, communicate about parenting and enhance child stimulation. For example, these rooms will include toys and materials that build motor skills, posters and graphics that help to develop linguistic skills. Drawing on the PHC facility's role as the key contact point, and recognizing the challenges facing pregnant women, increased support (training and materials) will be provided so that PHC facilities workers are better able to provide prenatal care and guidance to parents on topics such as early stimulation and nutrition. In addition, equipment and supplies, and training for the expanded BP will be provided. This will include: basic ECD-oriented toys and materials for child stimulation; supplies to establish ECD toy libraries; materials for antenatal care as well as other supplies and equipment. Existing PHC staff without specialist training will also undergo the six-month retraining course in family medicine at the closest Family Medicine Training Center. This component will also finance the supervision the implementation of the CGDM Program through the State Surveillance Service over Medical Activities and Social Protection.

24. **Increased support to enable implementation by PHC workers and supervision by MoHSP of the CGDM Program.** This component will provide additional training to PHC workers including PHC nurses to take part in early child stimulation in the PHC facilities and during the household visits. Household visits will be based on the assessment of the risks and outcomes of the CGDM Program. This component will also support the supervision of the CGDM Program. Activities for the 0 to 3 year old children will be led by the MoHSP, along with the district-level administrations, and supported by the PIG, starting in the second year of project implementation, on the basis of the district ECD plan. Some training will be conducted jointly with the MoES to ensure synergies for PHC workers and preschool teachers and CCDG facilitators.

For 3-6 year olds

25. The objective of this sub-component is to expand access to preschool education opportunities for 3-6 year old children in targeted districts, with the priority placed on 6 year old children to ensure all children have at least one year of preschool education before starting primary school. This will be achieved by creating and operationalizing more KG



and ELC spaces and introducing CCDGs to Tajikistan in existing spaces in the communities, as defined in approved district ECD plans to be developed under sub-component 3.1.

26. The project will finance: (a) construction of new KGs as per the new design (see sub-component 1.1), retrofitting existing spaces to accommodate new students, and construction and retrofitting of ELCs; (b) establishing CCDGs; (c) training of existing and new teachers, facilitators, coaches in target districts and other staff, as well as teachers hired by the MoES to work in ELC classrooms built under the GPE/IsDB Basic Education Project; (d) procurement of classroom furniture and equipment; (e) development/printing and distribution of TLMs to all KGs, ELCs and CCDGs supported by the project; and (f) quarterly coaching visits to KGs, ELCs and CCDGs supported by the project. The teaching and learning materials provided to CCDGs will be of sufficient quantity to enable caregivers to borrow materials to take home and read or used to play with their children.

27. In the first year of project implementation, *mahallas* and districts will be assisted to conduct needs assessment to collect information and data in order to prepare the district ECD plan. An indicative budget envelope will be provided to enable district to have a feasible plan (see sub-component 3.1). Recruitment of preschool teachers, CCDG facilitators and other required support staff will need to initiate during the first year. The current cadre of methodologists at the District Education Department (DED) will have to be also increased to ensure sufficient staff are available to carry out quarterly visits to KGs, ELCs and CCDGs to support and mentor teachers and facilitators. MoES will be leading this activity in coordination with district administrations who will be responsible for the recruitment of the teachers and methodologists, as is their current mandate. Each KG's methodologist will get training to be the coach for other teachers in the KG and other nearby preschools if appropriate. The facilitators are working on a volunteer basis and communities will be responsible for identifying volunteer facilitators to provide support in establishment and operation of CCDGs. While recruitments are taking place, TLMs for KGs and ELCs will be produced based on those currently approved by the MoES. So as not to slow down project implementation, review and revision of these approved materials will also take place, and once the revised materials are approved by MoES for national implementation (expectedly in later years of the project), trainings will be revised accordingly, and the revised materials produced and distributed to project supported preschools. As CCDGs are an innovation to Tajikistan, although there are no existing approved TLMs, there are materials and good practices available around the world which can be easily adapted into the country context. TA will support the development of these materials based on best practice from other countries, adapted to the local context.

28. Existing and new teachers and facilitators in the target areas will receive training in the relevant curricula, and, once revised, as appropriate for the preschool model(s) they are responsible for delivering. Training activities will follow the current process implemented by the government, which is executed in coordination with the Regional In-Service Institute for Teacher Training as an Institute for Professional Development. Training of the trainers will be carried out at the national level, with teacher training carried out at the provincial level. Training will comprise different stages (a) first intensive training; (b) direct coaching sessions every quarter; and (c) additional regular support using other means (such as information and communications technology) to ensure teachers and facilitators continue to improve their teaching and facilitating practices after they have received training. Existing and new methodologists at the district level will be responsible for carrying out coaching and mentoring quarterly. Refresher training will also be provided to teachers and facilitators annually.



29. During the second year of implementation, the project will support civil works to create additional preschool spaces according to approved district ECD plans. Existing KG and ELC spaces could be retrofitted and rehabilitated to accommodate more students or rebuilt in instances where it would be more expensive to rehabilitate. New and rehabilitated buildings will include improved access to water and sanitation, quality and safety of infrastructure that are resilient to climate and geophysical hazards, cost effective, safe, and energy efficient, such as through improved lighting, heating, windows and insulation, and appliances. New constructions of KGs and ELCs will also be supported, with preference placed on building on existing school land. In instances where new land is identified as most appropriate, the district will identify and allocate land, and the MoES will assist in obtaining permissions, and following resettlement procedures as laid out in the government's Resettlement Policy Framework developed for this project. The project will also support retrofitting and rehabilitation of existing community venues to serve as preschool spaces (ELCs or CCDGs). Preschool infrastructure improvement will be aligned with the new design specifications, which will be reviewed and improved under Component 1, to ensure efficient utilization of public investments that benefit more children, especially those from more disadvantaged groups. All project-supported venues will be appropriately provided with furniture, equipment and TLMs procured and developed during the first year of implementation.

30. In localities where existing infrastructure or budget allocated for the community BP is not sufficient to cater to all children from 3-6 years old participating in the preschool program, priority of seats should be given to children of 6 years and over to enable them to attend at least one full year of school preparation prior to starting primary school. Children younger than 6 years old will be provided opportunities to attend learning-through-playing sessions with their caregivers through CCDGs. This community-based model is a new innovation to Tajikistan, providing caregiver awareness around the importance of engaging with their children in stimulating, play-based activities designed to foster improved child development outcomes. Sessions are interactive with both caregivers and children, with activities arranged by children's age groups to engage in early stimulation and early learning with peers and adults in a safe environment. CCDGs usually offer at least two sessions per week, each lasting around two hours. Activities are facilitated by volunteers selected by the community, who will be trained under the project to organize activities for caregivers and children, providing both awareness raising of caregivers, and opportunities for caregivers and their children to engage in stimulating activities. This alternative preschool model will be opened for children from 0-5 years old. Communities interested in establishing CCDGs will be responsible to identify an existing venue to host the groups, and the project will provide support for operationalizing them. Potential venues could be community library, schools, KGs or ELCs venues during weekend. The establishment of these CCDGs will include: (a) provision of resources for setting up CCDGs; (b) selection and recruitment of facilitators at community level to run CCDGs; (c) provision of training for community facilitators to facilitate and organize CCDGs; (d) provision of training for caregivers in topics related to ECD including health, nutrition and early stimulation; (e) development of materials and production of resources for functional CCDGs; and (f) local government involvement in implementation support and monitoring.

31. The TLMs provided to CCDGs will include sufficient quantities of educational toys and children books to allow families to take some home on a loan basis. The resources will cover different age groups from 0-6 years old, and will be managed by the CCDG facilitators, who will receive training and guidance on managing, monitoring and making resources available to end users. Resources will be replenished during project implementation, depending on resource availability. A small-scale operating grant will be provided semi-annually to the *mahalla* committees to manage and operate CCDGs.



32. *Sub-component 3.3: Monitoring the ECD plan implementation progress at district and mahalla level.* While the CGDM and EMIS systems would provide data for monitoring the implementation of ECD plans, additional data would be required for monitoring attendance and CCDGs. For CCDGs, data collection from ELCs and KGs would mirror data collection currently conducted under the EMIS and would ideally be ultimately integrated with the EMIS system. Attendance data is currently not being collected under the EMIS system. TA would be provided to develop an approach for collecting attendance data, including quality assurance. TA would also be provided to develop provide timely reports of enrollments to *mahallas* and districts for monitoring of the ECD plans. The project will finance TA to support district- and *mahalla*-level staff in carrying out data collection.

33. *Sub-component 3.4: Strengthening local accountability and citizen engagement.* The project will engage parents and communities in the implementation of activities across the project, building on existing systems to engage parents and community members and working at the community level to identify needs and gaps in services promoting improved ECD outcomes. In addition, as noted above, synergies with the recently approved community-driven development projects CSP and SERSP offer platforms for deeper engagement working with *mahallas* and community-subcommittees. Two mechanisms for engagement are planned, one using SMS and the other a participatory planning and monitoring mechanism. The SMS-based information and beneficiary feedback mechanism, "Mobile Engage", will enable geographically-targeted information dissemination to inform beneficiaries on project-related activities, and provide a free automated SMS-based interface (using Interactive Voice Response technology) through which parents and community members are encouraged to provide feedback on any ECD related issue they wish to share, provide feedback on, and file complaints.

34. The second mechanism is where there are ECD spaces established, a participatory planning and monitoring mechanism through women's (or parent) groups will be engaged in a process of monitoring the performance of their PHC facilities and preschools around a set of simple indicators (timeliness, cleanliness, equitable treatment of all children), which facilitate dialogue through semi-annual action plans undertaken jointly by parents, community members and PHC and preschools staff. These action plans can be discussed at a "Check My Kindergarten/How-are-we-doing?" workshop organized to enable the whole community to provide periodic feedback on the quality of services in PHC facilities and preschools, and to verify that all promised inputs (e.g., furniture, equipment and learning materials, etc.) have indeed been supplied. The project also proposes to supplement the survey platform L2T with consultative parents' forums at the *Jamoat* level. The project will finance costs related to: (a) implementation of the "Mobile Engage" system; and (b) workshops.

Component 4 – Project management and coordination (US\$3.0 million)

35. **This component will provide support for the execution of project management and coordination activities.** The component aims to provide daily support for execution of the project interventions to ensure implementation progresses smoothly according to agreed plan. A PIG will be established with specific responsibilities to provide support and coordinate implementation of project activities. The PIG will comprise experts who meet the requirements defined in each position's terms of reference satisfactory to the Bank. The component will finance: (a) PISP; (b) external consulting services required; (c) office supplies, equipment and operating costs of the PIG and the district coordinator offices; (d) training for PIG and all concerned parties, as needed for project implementation; (e) audits, and operating costs, including travel for study tours and supervision; (f) workshops and conference, as agreed with the Bank, to facilitate good practices and share lessons learned across; (g) project M&E activities, project transparency and citizen



feedback not covered under component 3; and (h) costs related to a Beneficiary Feedback Mechanism, including a Grievance Redress Mechanism, as described in the Environmental and Social Commitment Plan.



ANNEX 4: ECONOMIC ANALYSIS

1. **Justification of public financing.** The primary economic justification of public financing of early age child development and education is the inability of households to borrow against future earnings of their children. Despite strong evidence of high benefits in terms of future productivity and earnings relative to costs of early age interventions, credit constraints prevent individuals from borrowing against future earnings to finance early interventions: this market failure is the primary justification for public intervention for ECD in general and applies to this project as well.

2. **World Bank's value-added.** The World Bank's value-added is its experience and expertise in implementing and evaluating ECD interventions previously in many different contexts. The World Bank has extensive experience supporting and evaluating ECD investments and policy reforms internationally. This includes supporting the upgrading of ECEC services including preschools, early learning centers and KGs, and it has been integral in the development and evaluation of playgroups in Indonesia and the South Pacific.

Current evidence on the effectiveness of key interventions

3. **Integration of ECD interventions.** Integrating health, nutrition and early stimulation interventions are believed to be the most effective approach for promoting ECD outcomes (Engle et al. 2007); the development and scaling up of integrated interventions remains and definition of best practice a priority area of research (Black & Dewey 2014; Hurley, Yousafzai & Lopez-Boo 2016). Integrated ECD interventions are largely justified by the effectiveness of nutritional interventions on child growth outcomes and early stimulation on overall child development, but little evidence on synergistic interaction between the two types of interventions has been found (Grantham-McGregor et al. 2014). The sensitivity of stunting in a child's first 1000 days and of child development interventions in the subsequent 1000 days has been well identified in the literature, the success of integration of interventions depends crucially on capacity including training, supervision and monitoring (Black, Pérez-Escamilla & Rao 2015).

4. **Increased utilization of pre-natal and early childhood health service.** The CGDM and provision of equipment and training to improve the capacity of PHC facilities is expected to increase utilization of health services by pregnant women and young children. Maternal health has been strongly linked to child outcomes through better delivery outcomes including reduced premature births and reduced low birth weights (Bhalotra & Rawlings 2011). A substantial body of research has linked stunting with lower cognitive and physical development in childhood (Prendergast & Humphrey 2014; Bhutta et al, 2013). The first 1000 days of a child's life have been shown to be most sensitive for reducing stunting (e.g., the 2008 Lancet Series on Maternal and Child Undernutrition). Child growth monitoring has been found to increase utilization of health services and ultimately nutrition (e.g., Milman et al. 2018).

5. **Group-based parent engagement on early stimulation.** Evidence is growing on the effectiveness of group-based approaches to improve parenting practices for early stimulation delivered as playgroups (Table A4.1). In Australia, studies found that playgroups improve the support that mothers receive through social networks (Hancock et al. 2015) and reduced development vulnerabilities by half (Gregory et al. 2016). In Indonesia, Nakajima et al. (2016) found that playgroups followed by kindergarten increased test scores in primary school by 0.42-0.43 standard deviations. In Tonga, a randomized-controlled trial found that supporting communities to establish playgroups increased literacy and numeracy domains of school readiness by 0.17 and 0.19 SD for disadvantaged boys and girls. The positive effects of playgroups on child development outcomes extend research on group-based approaches more broadly, including the effectiveness of group-based approaches to promote parenting practices for nutrition (O'Rourke et al. 1998; Prost et al.



2013).

TABLE A4.1 EVIDENCE ON EFFECT OF PLAYGROUPS ON CHILD OUTCOMES

Study	Country	Effects	Evaluation method
Hancock et al. 2015	Australia	increased friendship network / social support for mothers	longitudinal study
Nakajima et al. 2016	Indonesia	Playgroups followed by kindergarten increased primary school test scores by 0.42-0.43 SD	regression model
Gregory et al. 2016	Australia	Reduced developmental vulnerabilities by half	regression model
Macdonald et al. 2018	Tonga	0.17 to 0.19 SD literacy and numeracy school readiness skills for disadvantaged boys and girls, respectively	RCT

6. **Center-based early childhood care and education.** A large body of evidence has established the effectiveness of high quality, center-based ECEC programs including preschools and early learning centers (e.g., reviews by Nadeau et al. 2010; Vegas et al. 2010). Long-term, randomized-controlled trials of preschool programs have found substantial benefit-cost ratios in terms of increased future earnings and public expenditure savings from decreased crime and sickness (Schweinhart et al. 2005). Table A4.2 presents a selection of studies and their effects on cognitive skills.

TABLE A4.2 IMPACT OF PRESCHOOLS ON COGNITIVE ABILITY IN STANDARD DEVIATIONS

Program	Study	Impact
Philippines ECD (ages 2,3) Program	Armecin et al. 2006	0.28 to 0.43
U.S. Pre-kindergarten	Magnuson et al. 2004	0.1 to 0.13
U.K. Preschools	Samons et al. 2007	0.069 to 0.071
Argentina National Preschool Program	Berlinski, Galiani, Gertler 2009	0.23 per year
Bangladesh Rural Preschools (4 to 6 year olds)	About 2006	0.13 to 0.17

Expected benefits of interventions targeting 0 to 3 year-old children

7. **Economic benefits.** While it is not possible to quantify the effects of the 0 to 3 year old BP interventions on the use of health services or subsequent outcomes, international research on the effects of improved nutritional outcomes suggests substantial economic benefits (Nandi et al. 2017; Wong & Orazem 2017). For example, maternal health provides economic benefits through increased survival rates, child growth outcomes, schooling and productivity (Alderman & Behrman 2006). Long-term studies have shown the benefits of stunting on schooling outcomes and productivity (McGovern et al. 2017). Benefit-cost ratios calculated for interventions to reduce stunting in 14 countries yield benefit cost ratios between 3.8 to 34.1 (Bhutta et al. 2013; Hoddinott et al. 2013).

Expected benefits of interventions targeting 3 to 6 year old children



8. **Cost-benefit methodology.** International evaluations of the interventions targeting 3 to 6 year old children (Tables A4.1 and A4.2) allow for modeling and estimation of an internal rate of return (IRR), a measure of the return on investment. This analysis models an IRR based on assumptions listed in Table A4.3 as well as a sensitivity analysis based on the information about the unknown parameters of the model. The assumptions aim to provide a *lower bound* IRR, and, as such, benefits in the model are limited to the effect of the interventions on increased cognitive ability and subsequently higher earnings as a measure of potential productivity. The effect of the interventions on cognitive skills is unknown as are the effect of cognitive skill on future earnings. These are treated as random variables in the model. The probability distribution of effects on cognitive ability is based on effect sizes reported in Tables A4.1 and A4.2. The distribution of effects of cognitive ability on future earnings is based on a summary table in Patrinos and Psacharopoulos (2010). An IRR is calculated for each combination of effects of the interventions on cognitive ability and effects of cognitive ability on earnings. This distribution of IRRs provides a sensitivity analysis and the average IRR is the estimated modeled IRR for the education interventions.

TABLE A4.3 IRR MODELING ASSUMPTIONS

Lower bound IRR assumptions
1. Including only benefits to a child who completes 1 year of playgroup, 2 years of both playgroup and ELC, and 1 year of KG--modeled number of beneficiaries is therefore the number of 3 year olds in playgroup, see Section C (beneficiaries)
2. Including benefit from increase in access to services, ignoring increased quality
3. Benefits only from increased earnings resulting from higher cognitive skills
4. Investments last 15 years after the project
Modelling assumptions
5. Age earnings profile based on Mincerian earnings function estimates using Blunch's (2010) estimates for Tajikistan, scaled to annual 2019 USD based on real GDP pc growth
6. Earnings grow based on IMF WEO 2019 October forecasts and 2.2% subsequently
Sensitivity analysis
7. Effect of 4 years of ECEC on cognitive skills range as in Tables A4.1 & A4.2 above
8. Effect of cognitive skills on future earnings range as in Patrinos and Psacharopoulos (2010)

Definitions: International Monetary Fund (IMF); World Economic Outlook (WEO)

9. **Investment and cost assumptions.** Investment amounts and the modeled recurrent cost per child by age of utilizing the services are presented in Table A4.4. The cost is modeled as a child attending playgroup at age 3, playgroup and ELC at ages 4 and 5, and KG in age 6. The recurrent cost includes the per child recurrent cost of the services the child is using (see fiscal analysis below). Playgroup costs exclude any donations or support from parents and community members as well as the opportunity cost of the volunteer facilitator.

TABLE A4.4 INVESTMENT AND COST PARAMETERS FOR IRR

Total investment cost (USD millions)	
Playgroups	14.3
Early learning centers	13.5
Kindergarten	6.1
Total	33.9
Recurrent cost per child accessing service by age	



age 3 (attending playgroup)	3.20
age 4 (attending playgroup & ELC)	67.46
age 5 (attending playgroup & ELC)	67.46
age 6 (KG)	269.40
Total	407.52

10. **Lower bound IRR and sensitivity analysis.** Figure A4.1 depicts the density of the estimated lower-bound IRR distribution. The distribution provides an estimate of the likelihood of the lower-bound IRR based on the different scenarios generated from effects of the interventions on cognitive ability combined with effects of cognitive ability on future earnings. The average lower-bound estimate is 8.49 percent; it has a standard deviation of 3.26 percent, a minimum value of 1.56 percent and maximum value of 16.18 percent This lower-bound is sufficient to justify the project as discount rates used in the literature for long-term investments that span more than one generation including ECD interventions are typically 3 to 6 percent (Engle et al. 2011), and because this is a lower bound estimate, the true IRR is expected to be much higher.

Figure A4.1. Lower bound IRR estimate and distribution

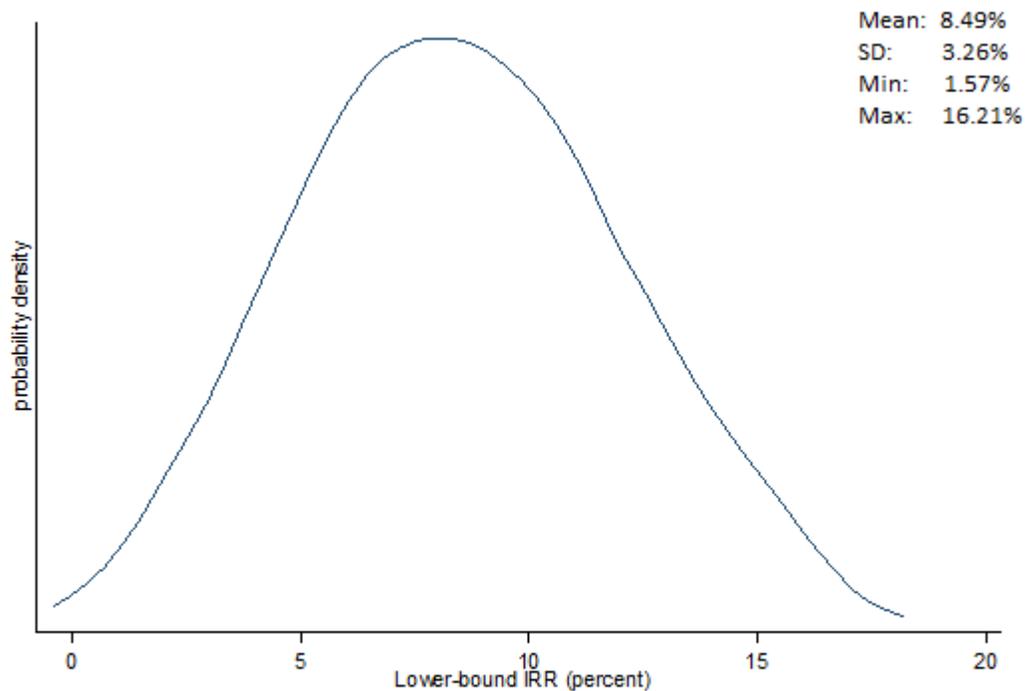


Figure depicts the probability distribution of the lower-bound IRR. The IRR depends on (1) the effect of the interventions on cognitive skills and (2) the effect of cognitive skills on the age earnings profile. These two are unknowns are treated as random variables with distributions based on effects measured in international literature (see assumptions) and determine the distribution of the IRR.

Fiscal sustainability analysis



11. **Fiscal impact of interventions targeting 0 to 3 year old children.** Table A4.5 presents the recurrent costs required to maintain the interventions targeting 0 to 3 year old children after the end of the project. Fiscal impacts are not expected during the implementation of the project. Annual recurrent costs include printing of ambulatory cards, additional training, and the replacement and maintenance of equipment which amount to US\$550,000. Domestic general government health expenditure for 2019 is estimated to be US\$163 million based on the 2016 (latest available) share of GDP, and the 2019 projection of GDP based on the IMF WEO October 2019. New recurrent costs are expected to represent a small fraction, 0.34 percent, of domestic government health expenditure.

TABLE A4.5. ANNUAL RECURRENT COSTS OF MAINTAINING THE 0 TO 3 YEAR OLD INTERVENTIONS AND FISCAL SUSTAINABILITY

Item	US\$
Printing of 250,000 ambulatory cards per year	250,000
Additional training per year	100,000
Replacement and maintenance of equipment	200,000
Total per year	550,000
As a percent of 2019 projected domestic general government health expenditure	0.34%

Note: estimated domestic general government health expenditure is assumed to be the same percent of GDP as the latest year of data available (2 percent of GDP in 2016). GDP projections for 2019 in the IMF WEO October 2019 edition are used.

12. **Fiscal impact of the interventions targeting 3 to 6 year old children.** Table A4.6 presents the effect of the project on the government's recurrent costs. Recurrent costs accrue through two channels. First, the increase in ELCs and KGs will require the government to provide staffing, materials and other resources as provided to existing ELCs and KGs. Second, the training and professional development CCDG facilitators, ELC and KG teachers would require ongoing coaching and mentoring. For the duration of the project, ongoing coaching and mentoring would be financed by the project, however, in order to be continued after the end of the project, the government would finance these. Note that the recurrent cost of providing staffing and resources for new ELC and KG children would be incurred by the government if the government increases enrollment. The coaching and mentoring are an additional, but small, portion of the recurrent cost required to improve the quality of these services. The implied increase in recurrent costs for the government would represent 7.36 percent of the 2018 pre-primary education budget and 0.46 percent of the overall public education budget. Note that the KG recurrent costs are expected to be lower because the current estimate is based on the national average per child KG cost which is skewed upwards by a large number of small KGs.

TABLE A4.6. FISCAL IMPLICATIONS OF THE EDUCATION INTERVENTIONS DURING IMPLEMENTATION AND CONTINUING AFTER THE END OF THE PROJECT

US\$ millions							annual after end of project
	2020	2021	2022	2023	2024	2025	
recurrent costs from new students (financed by government)	0.00	0.08	0.51	0.94	1.32	1.62	1.62
recurrent costs from coaching (financed by project)	0.00	0.05	0.10	0.16	0.20	0.24	0.00
recurrent costs from coaching (financed by government)	0.00	0.00	0.00	0.00	0.00	0.00	0.24
total new recurrent costs financed by government	0.00	0.08	0.51	0.94	1.32	1.62	1.86
...percent of 2018 preprimary budget	0.00%	0.32%	2.03%	3.73%	5.23%	6.41%	7.36%



... percent of 2018 public education budget	0.00%	0.02%	0.13%	0.23%	0.33%	0.40%	0.46%
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ANNEX 5: DETAILED SECTOR CONTEXT

Conception to Age 3

1. **The first 1,000 days of life are critical for child development and Tajikistan’s maternal and child health outcomes indicate there is a need to strengthen interventions during that period.** Brain neuronal development peaks during this period. Poor nutrition, unresponsive parenting practices and lack of stimulation can lead to lower cognitive development and poorer lifetime outcomes. Under five child mortality has fallen from 43 deaths per 1,000 live births in 2012 to 33 in 2017 (Demographic and Health Survey 2017) but is still above the average of the Central Asia Countries (23 per 1,000 live births), with Kyrgyz Republic and Uzbekistan reporting 20 and 22.5 deaths per 1,000 live births respectively, and the ECA regional average is only 9. There are significant regional variations within Tajikistan, from 11 to 40 deaths per 1,000 live births in Dushanbe and Khatlon, respectively. Malnutrition indicators have also improved, but under-5 chronic malnutrition (stunting) remains high at 18 percent nationally, and 32 percent in Gorno-Badakhshan Autonomous Region (GBAO).

2. **Stunting represents a complex challenge with varying risk factors across the country, including poor feeding practices and sanitation.** A recent study on drivers of stunting found that the risk is concentrated in poorer, rural parts of Tajikistan. Stunting is highest among children with several overlapping risk factors, identified as non-exclusive breast feeding for children under 6 months old, poor access to safe drinking water and sanitation, sub-optimal maternal and child caring practices (for example use of formula with contaminated water rather than exclusive breast feeding), and inadequate availability and diversity of food.⁵³ The prevalence of these risk factors varies across the country, as reflected in Table A5.1. In addition, the low level of exclusive breast feeding, in the context of the poor sanitation, increases the likelihood that diarrheal disease is a key factor causing chronic malnutrition and infant mortality.

TABLE A5.1: MATERNAL AND CHILD HEALTH INDICATORS AND RISK FACTORS VARY ACROSS THE COUNTRY

	Weighted average	Dush-anbe	Sughd	DRS*	Khatlon	GBAO**
Demography and income						
Population (2016, in million)	8.55	0.80	2.51	1.97	3.05	0.22
Official poverty rate (2018, %)	29.5	18.1	19.0	32.4	37.4	39.3
Female-headed households (2017, %)	21	-	-	-	-	-
Health and nutrition						
Infant deaths per 1,000 live births (2017)	27	9	26	25	33	26
Under-5 deaths per 1,000 live births (2017)	33	11	33	30	40	30
Stunted children under 5 years (2017, %)	18	18	16	15	19	32

⁵³ Lavado, Rouselle F.; Seitz, William Hutchins; and Alessia Thiebaud. Childhood Stunting in Tajikistan: Quantifying the Association with WASH Food Security, Health, and Care Practices. HNP Discussion Paper. Washington, DC: The World Bank. 2017



Low birth weight children (2018, %)	5.3	-	-	-	-	-
Children that are exclusively breast fed (2017, %)	34	-	-	-	-	-
Children (aged 6-23 months) fed according to the three IYCF*** practices, (2017, %)	9	7	13	5	10	8
Women of reproductive age (15-49 years) with anemia (2017, %)	41	36.1	39.9	33.3	47.3	54.9
Water and sanitation						
Households with no access to sewage disposal, (2017, %)	73	19	76	85	80	88
Households with no access to piped water, (2017, %)	67	8	70	72	80	89
Households with no toilet in the house, (2017, %)	78	21	82	89	88	90

Sources: Government of Tajikistan (2019), Demographic and Health Survey (2017)

*DRS: Districts of Republican Subordination

**GBAO: Gorno-Badakhshan Autonomous Region

***IYCF: This refers to infant, youth and child feeding practices. Three practices are food diversity, feeding frequency, and consumption of breast milk or milk

3. **In addition, the wider macroeconomic context has constrained spending on ECD.** The government spending on health is extremely low, at less than US\$20 per capita in 2018.⁵⁴ Its fiscal decentralization forces provincial and district authorities to cover more than 80 percent of health resources which burden household's out of pocket expenses for health services (more than 60 percent), particularly for the poor. Furthermore, in the health sector, there have been long-standing constraints in the integration and resourcing of the health system, which raise a sustainability challenge for ECD initiatives supported by development partners. However, the government commitment for a cross-ministry engagement offers a political window to build towards a more sustainable approach.

4. **The training of the PHC workforce in child health, growth and development could also be deepened.** The current financing structure also limits the attractiveness of PHC for health workers and predisposes towards informal payments. To increase the prestige and quality of PHC, specialized training for PHC doctors and nurses has been developed by development partners, but the government has not yet committed to take over the funding of this training. At the time of independence in 1991, Tajikistan did not have a family medicine model of care. Many doctors and nurses still working in PHC in Tajikistan have not received specialist training in PHC, including child health and development aspects. A six-month family medicine retraining course has been developed and is provided through the National and Regional Family Medicine Training Centers financed with support of the Health Services Improvement Project (P170358).

Age 3 to 6 years old

5. **Preschool education, a national priority with an ambitious expansion plan, is the principal avenue of Government policy supporting the ECD needs of children in the 3-6 year age group.** The MoES is officially mandated to

⁵⁴ National Health Account data.



address ECD and education needs of children 1.5 to 7 years old. The NDS for 2030, which was also announced by the President in his State of the Union Address in December 2018, noted the importance of increasing access to preschool education, reaching 30 percent children 3-6 years of age through preschool institutions by 2021; and 50 percent by 2030. The preschool enrollment rate in Tajikistan, at 13.3 percent in 2017, is among the lowest in the world⁵⁵, and far below comparable regional averages, including Central Asia (37.5 percent), Sub-Saharan Africa (33.2 percent) and South and West Asia (24.8 percent).⁵⁶ Achieving the national targets will require substantial, sustained investments, and a blend of innovative approaches to address the needs of a rapidly growing population.

6. **The strategic prioritization of preschool education is a sound and timely policy initiative and would have tremendous impact on tackling the learning crisis in the country.** Despite high levels of adult literacy at independence in 1991, Tajikistan has experienced a visible decline in the quality of learning and preschool education. Children in Tajikistan can expect to complete 10.8 years of pre-primary, primary and secondary school by age 18. However, when years of schooling are adjusted for quality of learning, this is only equivalent to 7.7 years; this means a learning gap of 3.1 years (Figure 4).⁵⁷ Quality investments in early learning bring short- and long-term benefits to the individuals and society in terms of higher learning performance, higher earnings, lower involvement in crime etc.⁵⁸ “The Skills Road”⁵⁹ report has also confirmed the positive correlation between education attainment, cognitive and non-cognitive skills and employment outcomes in Tajikistan and recommended an expansion of access to quality ECD as one of five priority policy interventions.

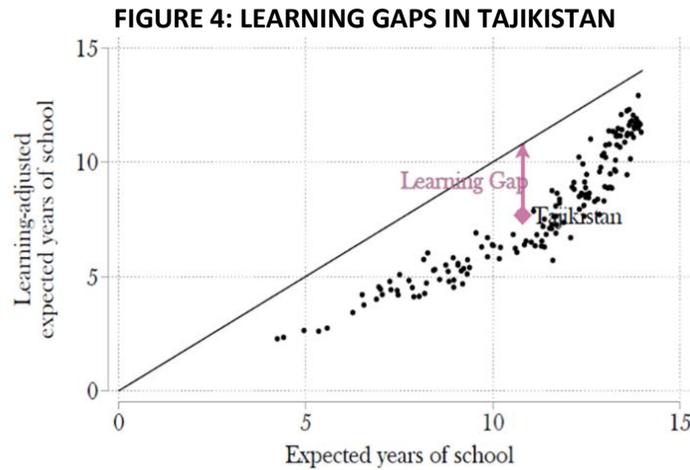
⁵⁵ The pre-primary sector of education suffered most after the devastating civil war following the country's independence in 1991, and many preschool buildings were demolished and abandoned. The Government's tight budgetary situation translated into a de-prioritization of the preschool sector, the high population growth and decreasing quality, led, along with the population poverty level, to a significant reduction in enrollment rates in 1990s and early 2000s.

⁵⁶ UNESCO Institute of Statistics (UIS)

⁵⁷ Human Capital Index, The World Bank. 2018.

⁵⁸ L. J. Schweinhart et al. The High/Scope Perry Preschool Study Through Age 40. Ypsilanti, MI: High/Scope Press. 2005.

⁵⁹ Ajwad, Mohamed Ihsan; Stefan Hut; Ilhom Abdulloev; Robin Audy; Joost de Laat; Sachiko Kataoka; Jennica Larrison; Zlatko Nikoloski; and Federico Torracchi. The Skills Road: Skills for Employability in Tajikistan. Washington, DC: The World Bank. 2014.



7. **However, preschool education is a fledgling and under-resourced subsector in Tajikistan, mostly providing services through traditional government-owned and managed centers.** Only recently, in 2018, the MoES established a preschool education department, responsible for policy making, ensuring service delivery, and monitoring quality. This recently established department has four staff. The budget for preschools increased from 2.1 percent of the total education budget in 2010 to 5.6 percent in 2017, but it remains minimal at 0.3 percent of the GDP, given the need to provide services to a rapidly growing population.⁶⁰ Preschool education is fee-based and implemented through: KGs (accounting for 67 percent of the enrolled students), ELCs (32 percent) and residential facilities (1 percent); provided mainly by the public sector (92 percent of institutions), and through a limited number of enterprise-owned and private centers.

8. **Low preschool enrollment is characterized by high levels of inequality.** Disparities in access are notable along regional, gender and socio-economic dimensions. For instance, although very low, urban areas have significantly higher enrollment rates than rural areas, with 30 percent enrollment in Dushanbe and only 2.3 percent in the DRS. There is a strong correlation between preschool enrollment and poverty. For example, the number of children enrolled in KGs and ELCs per 1,000 poor people in Nurobod and Rasht with the highest poverty rates (35–40 percent) is 10 and 22, respectively, and 726 and 319 in Dushanbe and Vahdat, respectively where the poverty rates are among the lowest. The share of girls enrolled in preschools is lower than boys and has fluctuated around 45 percent between 2010 and 2017. Early learning services to children with special needs are negligible.⁶¹

9. **Lack of infrastructure and low quality of the existing preschool facilities are significant contributing factors to low enrollment in preschools.** In 2017, there were only 615 KGs across the country, and the coverage was conspicuously low in rural and poorer areas because KGs are mainly located near the more densely populated centers of districts. In some districts (e.g., Khamadoni, Jilikul, Kumsangir), there is only one KG (on average enrolling about 300 students) for 12,000 preschool age children. This was confirmed by the ECEC analysis that physical distance from residence to preschool services is a significant barrier to access across regions and among families with different socioeconomic background.⁶² Most ECEC facilities have unsatisfactory heating, water and sanitation, electricity and communication systems, and classroom lighting, and do not meet the state standards.

⁶⁰ Between 1991 and 2016, the population of children aged 0-7 grew by around 23 percent (326,000 kids), of which the population of 3-6 year old children rose by around 26 percent (185,000 kids).

⁶¹ Early Childhood Education and Care Analysis: A Focused Review of Preschool Education in Tajikistan. Washington DC: The World Bank. 2019.

⁶² Ibid.



10. **Poverty and financial contributions from households prevent many children from accessing preschools.** Fees, used primarily to finance meals, have increased from 19 percent in 2015 to 34 percent in 2018 in state KGs.⁶³ Likewise, ELCs charge TJS50 on average per month to cover teacher salaries, which are not covered by the state. The current level of fees in the state KGs and ELCs is not affordable for the bottom 40 percent of the population.⁶⁴ For instance, the minimum monthly fee contribution for preschool (TJS50 per child)⁶⁵ accounted for a quarter of the average living expense of people living below national poverty line in 2017 (TJS190 equivalent to US\$22.40⁶⁶ per person per month). The required fee contribution is 150 percent larger than the cash benefits provided to low-income families (TJS33.3 per household per month, equivalent to US\$3.4) by the TSA. Obviously, this is unaffordable for children from low income families to access preschool services.

11. **Quality of preschool services is a concern, especially in rural areas, resulting from a combination of inadequately trained teachers and outdated TLMs.** In 2017, only 50 percent of professional staff in preschools had a pedagogical degree in secondary or higher education.⁶⁷ Lack of pedagogical competencies, especially for young age groups of preschools, among certified teaching staff is an indication of inadequate quality of pre- and in-service teacher training, which in turn are considered inflexible and outdated. The mandatory preschool curriculum, *Rangincamon* (“Rainbow”), developed in 2010, is not fully implemented in preschools, and needs to be updated for preschool age groups with new approaches to “learning through playing”. An assessment of preschool facilities and services in 2016⁶⁸ revealed an overall low quality of educational services with rural preschools underperforming—in terms of physical infrastructure and quality of learning interactions—compared to urban preschools. Principal contributing factors include low qualifications of teachers, weak pre- and in-service training programs, and outdated TLMs.

12. **It is therefore no surprise that the impact of preschool attendance varies across regions, instead of demonstrating a strong positive influence on all areas of child development.**⁶⁹ The findings of a nationally representative survey of children from 0-6 years old conducted in 2019 using eHCI found that the overall child development outcomes score is rather low, at 0.54 on a scale of 0 to 1; however, scores were particularly poor in some of the more formal or academic domains of development like pre-literacy and pre-numeracy (see Figure 5), likely in part due to the low preschool attendance rates. While child development scores improve as children get older, even children aged 6 years old still only scored 0.68 overall (see Figure 6). A World Bank study indicated a high tendency for preschool teachers to implement formal pedagogical approaches to learning, as is the practice in primary school and above, rather than a “learning through playing” approach, which is proven to be more effective for younger age groups. A shift in mindset may require significant efforts in capacity building and professional development.

⁶³ Ibid.

⁶⁴ Ibid.

⁶⁵ Fee ranged from TJS 50-100 (US\$ 5-11 equivalent) in 2017 and from TJS 55-110 in 2018/2019.

⁶⁶ As per the average market US\$/TJS exchange rate in 2017 at 8.49.

⁶⁷ E. Yudina. Preschools' facilities and services assessment GPE-4 project. 2016.

⁶⁸ Ibid.

⁶⁹ Brinkman & Sincovich, 2019.



FIGURE 5: AVERAGE CHILD DEVELOPMENT SCORE ACROSS NATIONAL SAMPLE

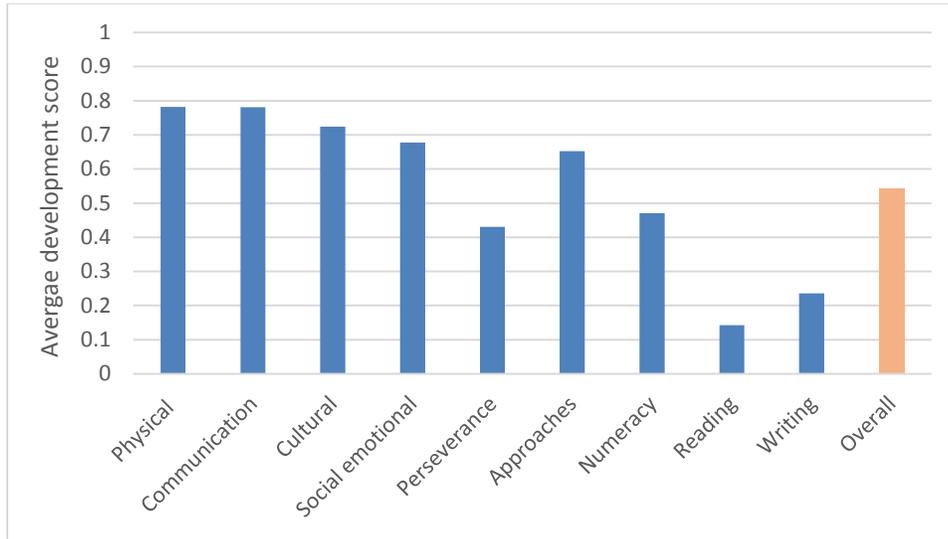
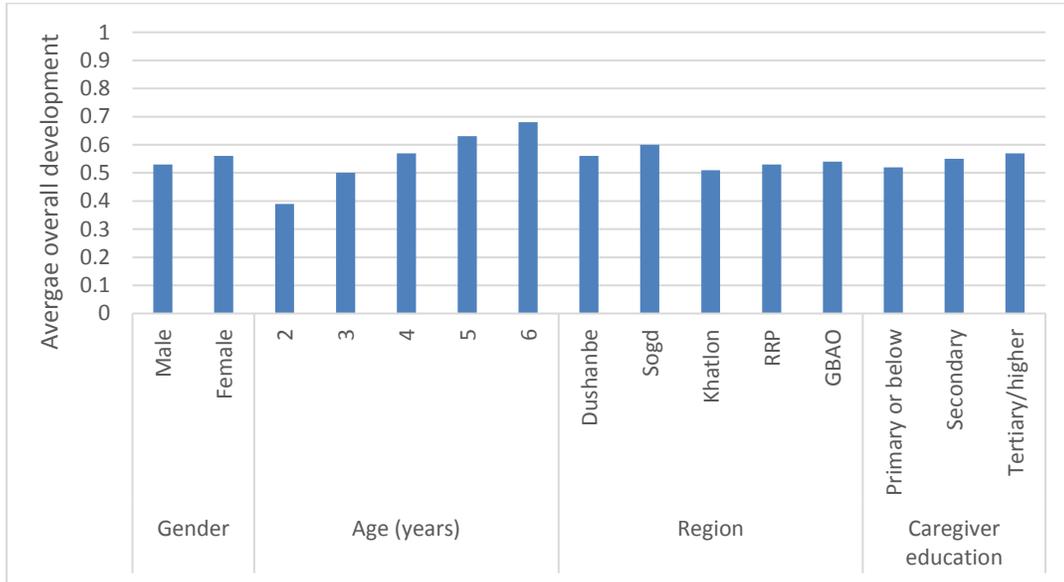


FIGURE 6: OVERALL CHILD DEVELOPMENT BY CHILD AGE, GENDER, REGION AND CAREGIVER'S EDUCATION



13. **Limited integration exists across services for ECD at all levels.** Existing curricula for health and education professionals place little to no emphasis on aspects of ECD outside of their own field. For example, health professionals do not receive training on discussing early stimulation with parents, and education professionals do not receive training on health and nutrition or identifying learning differences and disabilities and inclusive education. There are no systematic linkages between the MoES and the MoHSP, either at the central or the local level to engage collectively in this area. Data on Children with Disabilities are maintained separately by the two line ministries (MoES and MoHSP), and show discrepancies. The early learning and development standards for 0-7 year old children have been developed by the MoES, but not adopted or approved by the MoHSP. Specialized KGs for children with disabilities have no health staff and preschool teachers are not equipped to work with these children. The requirements are in place to stimulate



parenting practices and transfer of knowledge from health providers to parents through maternity and childhood health consultations. But these standards are neglected in health provision because of low funding, a lack of professionals, and a lack of materials. In preschools, interactions between teachers and caregivers is limited to discussions around preschool issues—there is no policy for communicating information on priority topics, such as the psychological and physical development of children in different age groups, or how parents and caregivers should motivate and support the development of children with special education needs.⁷⁰

⁷⁰ Early Childhood Education and Care Analysis: A Focused Review of Preschool Education in Tajikistan. Washington DC: The World Bank. 2019.