Combined Project Information Documents / Integrated Safeguards Datasheet (PID/ISDS)

Appraisal Stage | Date Prepared/Updated: 28-Oct-2019 | Report No: PIDISDSA27332

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Project Name	Parent Project ID (if any)
Tajikistan	P170358	Second Additional Financing to the Tajikistan Health Services Improvement Project	P126130
Parent Project Name	**Region**	**Estimated Appraisal Date**	**Estimated Board Date**
Tajikistan Health Services Improvement Project (HSIP)	EUROPE AND CENTRAL ASIA	07-Oct-2019	18-Dec-2019
Practice Area (Lead)	**Financing Instrument**	**Borrower(s)**	**Implementing Agency**
Health, Nutrition & Population	Investment Project Financing	Republic of Tajikistan	Ministry of Health & Social Protection Project Coordination Group, Ministry of Health & Social Protection

Proposed Development Objective(s) Parent

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

Components

Component 1: Performance-Based Financing
Component 2: Primary Health Care Strengthening
Component 3: Project Management, Coordination, and Monitoring & Evaluation

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	12.00
Total Financing	12.00
of which IBRD/IDA	10.00
Financing Gap	0.00

DETAILS

World Bank Group Financing	
International Development Association (IDA)	10.00
IDA Grant	10.00
Non-World Bank Group Financing	
Trust Funds	2.00
Integrating Donor-Financed Health Programs	2.00

Environmental Assessment Category

B-Partial Assessment

Decision

The review did authorize the team to appraise and negotiate

Other Decision (as needed)

B. Introduction and Context

Country Context

1. **In the last decade, Tajikistan has made substantial progress in reducing poverty.** Extreme poverty in Tajikistan, measured by using the international poverty line of US$1.90 per day, fell from 54 percent in 1999 to 5 percent in 2015. With a large, and increasing, number of migrants, remittances account for between one third and one half of Tajikistan's gross domestic product (GDP) and have contributed to overall poverty reduction. In addition to remittances, high public expenditures have also supported GDP growth, which has, in turn, fueled domestic consumption and public investment.

2. **Further progress on the Twin Goals has been constrained by economic policy choices and, until recently, by Tajikistan's relative isolation.** Two potential contributors to more sustainable GDP growth, and thus to a potentially faster rate of poverty reduction - private investment and exports - have remained low. Beyond the outflow of people, Tajikistan's legacy of relative isolation stems from being a landlocked, mountainous country in a region with a long history of disrupted trade flows. This has prolonged the inward orientation and centralization of economic management and resulted in a large, state-operated sectors and underdeveloped markets. Tajikistan's economic policy choices have constrained its export potential and increased the economy's susceptibility to exogenous shocks, as witnessed by the impact from the global post-2014 commodity price collapse in triggering Tajikistan's 2016 financial and economic crisis. The large government bailout of banks had an immediate negative impact on fiscal accounts and

will likely have longer-term repercussions on the macroeconomy. Combined with a development strategy that has favored large public investments, straining fiscal resources, Tajikistan remains a country at high risk of debt distress. Adding to these vulnerabilities, Tajikistan is one of the most vulnerable countries in the region to the impacts of climate change, including natural disasters.

3. **Moreover, social vulnerabilities and fragility risks persist for a number of reasons.** These include the legacy of the 1992–97 civil war, persistent pockets of poverty, especially in lagging regions, income insecurity, under- and unemployment, and security risks emanating from the 1,400-kilometer border with Afghanistan. Many of the resulting fragilities are comparable to those encountered in other post-conflict countries. More than one in three youth, and almost nine out of ten female youth, are not in employment, education, or training, with considerable segments in society, such as returning and deported migrants or abandoned wives, being largely excluded from local communities.

Sectoral and Institutional Context

4. **With high population growth rates, Tajikistan needs to ensure a proper balance between export-generating infrastructure and productivity-raising investments in better health**. Children under six years of age comprise 17 percent of the population and, at present, one out of three Tajiks are under 15 years of age. At 29 births per 1,000 people in 2016, Tajikistan has the highest birth rate in the ECA region. Tajikistan's *Human Capital Index* (HCI) indicators are lower than the average for its region, but higher than the average for its income group. A child born today in Tajikistan is expected to be 53 percent as productive as he or she could be growing up with complete education and full health. Considerable challenges remain for the very young, with rates of stunting being the highest in the region. During 2012–17, stunting among the under-five population was reduced from 26 to just over 21 percent, but ensuring proper nutrition and reducing inequities in access to essential child health services, such as vaccinations, remains a challenge. Thankfully, interventions aimed at increasing food availability through house gardens, education, by promoting good feeding practice and child disease management, have yielded tangible results.

5. **Health outcomes, in general, and those for maternal and child health (MCH) in particular, lag those in other countries in Central Asia or the South Caucasus.** Poor infant feeding practices, limited access to nutritious food, and a high disease burden have resulted in an estimated under-five mortality rate of 45 per 1,000 live births. While this has declined consistently since the mid-1990s, it remains high and reflects the low coverage of priority MCH and reproductive health services, including for critical areas, such as counseling on nutrition (an especially important problem for children under five). Service delivery is particularly challenging given the country's mountainous terrain, which covers around 93 percent of the landlocked country. Despite many efforts to improve the financing, capacity, and physical infrastructure of PHC, these have not yet translated into better service quality. Apart from the challenging geography, a critical factor in persistently low-quality services is the incentive structure facing providers of services.

C. Proposed Development Objective(s)

Original PDO

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

Current PDO

The revised PDO is to contribute to the improvement of the coverage and quality of basic primary health care (PHC) services in selected districts.

Key Results

D. Project Description

6. **The second additional financing (AF2) will scale-up the coverage of Performance-based Financing (PBF) and quality improvement activities in underserved areas, as well as strengthen demand for primary care services through community outreach.** The overall Project design remains unchanged, but the AF2 will extend activities already under implementation under the parent Project as described below by component.

COMPONENT 1: Performance-Based Financing (US$5.975 million AF2, of which Gavi co-financing US$1.135m).

7. **Continuation of a streamlined PBF scheme.** During the first year of the AF2 (calendar year 2020), PBF will continue to be implemented in the ten pilot PBF districts in a streamlined manner. While the quality of primary care will continue to be incentivized according to a quality scorecard, the quantity payments will focus on selected MCH and NCD services as tracers of integrated primary care. These include child health services of vaccination, postnatal counseling, growth monitoring, and treatment of malnutrition. Indicators on hypertension diagnosis and treatment in the original Project will be retained, due to a recent World Bank study[1] that found 10% or less of adults with hypertension are diagnosed and registered in a health facility in Khatlon and Sogd regions, with the probability of blood pressure control in the entire hypertensive population less than 2%. Incentive payments associated with each of these six indicators will be reduced to be more sustainable for local authorities to track and monitor. A seventh indicator will incentivize health workers to visit each household in their catchment area for the purpose of creating a patient registry and for patient engagement activities, described below. The revised PBF manual will be prepared by the PCG ahead of the effectiveness of the AF2. Quarterly internal verification by the State Surveillance Service on Health and Social Protection Activities (SSSHSPA, known by its Tajik short name of Khadamot) will be conducted as per the original Project.

8. **Scaling-up of PBF to underserved areas to improve quality of care**. During the first year of implementation of the AF2, an additional set of districts will be selected and prepared for the implementation of streamlined PBF. Districts will be selected based on a multi-dimensional index of need (including vaccination coverage and poverty rates) in discussion with the government. Districts selected

[1] Chukwuma, A. et al. 2019. Strengthening Service Delivery for Hypertension in Tajikistan. Washington, DC: World Bank Group

will not be part of the Early Childhood Development Project under preparation to avoid duplication. Preparation for PBF will involve: (i) a facility mapping exercise undertaken by the Project Coordination Group (PCG) to determine which facilities require minor refurbishment (with an upper threshold of funding), provision of internet, and the purchase of computers and medical equipment necessary to support the PBF interventions; and (ii) training of health workers and district management teams in PBF principles and computer literacy, using the revised PBF manual. PBF will commence in these new districts over the second year of implementation. The extended PBF scheme will require an upgrade of the PCG server, as well as new software for data protection as required by the Government of Tajikistan.

9. **Household engagement visits to create an understanding of and demand for primary care services to strengthen incentivized services under PBF.** This activity will build on currently mandated household visits (Podvorovoy obkhod) where primary care nurses and doctors visit households in their catchment area to assess the health status of family members. Under AF2, these visits will be made more comprehensive through (i) taking a census of household members; (ii) assessing the health needs of household members; (iii) providing information on appropriate services available at the local primary care facility; (iv) creating a follow-up plan for relevant services incentivized under PBF; and (v) providing information on grievance redress mechanisms. Training will be provided to health staff in existing and new districts.

10. **Internal verification.** Quarterly internal verification will be conducted by KHADAMOT, as per the original Project. Capacity building for KHADAMOT will be undertaken at the national and subnational level, including training and office equipment, to strengthen service capacity in preparation for national scale-up and transition to government ownership.

11. **External verification of PBF.** External verification of PBF during 2020 will be conducted by UNICEF but will be paid for outside of the Project, directly by Gavi (i.e. not part of co-financing). After January 1, 2021, some funds will be allocated to UNICEF under an amended or new Memorandum of Understanding to undertake external verification of PBF as under the existing scheme.

12. **Patient registries**. With the support of an international consultant and to better plan, finance, and implement health services in a targeted manner the project will finance the creation of a digitized facility-specific population registries in all PBF districts. This will involve data collection through household engagement visits, data entry, training the responsible personnel.

13. **Deepening of per capita financing (PCF), including the integration of PBF payments and pilot testing of population registries.** Under AF2, an international consultant will advise on changes that can be made to ease identified bottlenecks to more effective PCF, for example, the move to a single budget line for primary care facilities or flexibility in moving funds across budget lines. An international consultant(s) will also advise on how PBF payments can be incorporated into the PCF payments, for example through an existing dormant financial mechanism in local authorities' budgets. This will be supported by separate funding from the Global Financing Facility in support of Every Women and Every Child (GFF) to overcome public financial management barriers to more efficient health

financing. Training on PCF and PBF, and population registry principles in primary care will be provided to regional and district managers to improve knowledge in these areas.

14. **Transition to government ownership and sustainability of PBF**. In both new and existing PBF districts, payments supported by the project will be discontinued after four quarters of implementation. District and facility managers will be officially informed of this transition by December 2019 to enable the development of sustainability plans in each district, with phased out support from the PCG for the original PBF districts in the second year of implementation. To strengthen independent verification of PBF results under government ownership, capacity building for KHADAMOT at national, regional and district levels will be supported under AF2. A Technical Working Group on Primary Care Financing has already been established and will develop an action plan for scaling up performance-based payments in primary care, their integration with the nationwide PCF scheme, and the deepening of PCF. The Technical Working Group (TWG) is to include representatives of the MoHSP, MoF, Inter-Agency Expert Group on Health Financing, KHADAMOT, the PCG, and all regional health departments.

COMPONENT 2: PHC strengthening (US$4.075 million AF2, of which Gavi co-financing US$0.0).

Sub-component 2.1: Quality Improvement (US$1.65 million AF2).

15. **Six-month family medicine training in new PBF districts for existing staff.** Under the current Project, six months of training in family medicine has been provided to existing nurses and doctors in the PBF districts. Under the AF2, this training will be extended to the staff of the new PBF districts as part of the capacity building plan, which will positively impact the quality of care provided by the facilities. The training will be conducted at the regional MoHSP Family Medicine Clinical and Training Centers for the staff of the new PBF facilities using the existing training material approved by the MoHSP.

16. **Primary care management training for all district managers and chief doctors.** An international consultant will be employed to develop a training course in primary care management skills. This course will be delivered to all district and facility managers (chief doctors) in primary care through the MoHSP Family Medicine Clinical and Training Centers, possibly in collaboration with the Postgraduate Medical Institute. It is estimated that around 1,000 participants nationwide will attend the course, which is feasible as the PCG has previously trained 825 doctors at a regional and central level in management. Primary care management skills such as planning, data analysis for performance, leadership, and community outreach have been noted to be bottlenecks to improved performance under the PBF scheme in the original Project. This training will include sessions on climate-related health issues and resiliency measures. This curriculum will be tailored to district and facility managers in terms of content as well as timing, considering that managers should not be away on training for longer than a week. In addition, the recently piloted PHC Business Planning model of the World Health Organization will be reviewed and, if feasible, included in the training package.

17. **Support for family medicine specialty training during transition to national funding.** It was noted in the qualitative study that mothers tend to associate provider competence with specialization. To improve the status of family medicine as a specialty, as well as the quality of primary care, the Swiss

Development Cooperation has been supporting the development and implementation of a national two-year post university specialty training in family medicine (known as the PUST program). However, this support is now being phased out, with a plan for a transition to state funding over five years. In this transition period to state funding, around 60 graduates from the Tajik State Medical University will be supported over a two-year period. These graduates will be selected from the new Project districts in the hope that they will return to their home districts to work after graduation from specialty training.

18. **Specialized software to improve the quality and coverage of child health services.** The PBF pilot has used an adapted version of District Health Information System 2 (DHIS2) in Project districts. To build momentum for the national DHIS2 initiative, the Project will support DHIS2 rollout in Project districts. Implementation is likely to be easier as the staff is already trained in computer literacy, and facilities have the necessary electronic infrastructure. This will include incorporation of the PBF system as a module in the DHIS2 software, which can then be scaled up nationally. DHIS2 has both a specific module for monitoring immunization and a messaging function, that can be used to engage families to build demand for vaccinations. Both functions will support the monitoring and mitigation of climate-sensitive diseases.

Sub-component 2.2: Physical Infrastructure Improvements (US$2.425 million AF2, of which Gavi co-financing US$0.495m).

19. **Basic medical equipment bags for primary care doctors and nurses.** These bags will contain basic medical equipment (stethoscope, blood pressure monitor, a thermometer to check the temperature is not raised before vaccination, otoscope, tape measure for growth monitoring, etc.). These will be distributed to: (i) family doctors and nurses in GBAO where the level of equipment is poor; and (ii) to newly trained primary care nurses and doctors in the new project districts following the six months family medicine training. By ensuring staff has the basic equipment to provide essential primary care services, this will directly strengthen the quality of front-line service delivery for child health.

20. **Minor rehabilitation, equipment, and solar panels for selected primary care facilities**. Based on a site survey by the PCG, selected primary care facilities in those districts where PBF will be scaled-up will receive minor rehabilitation, computers, and basic medical equipment to ensure basic functionality and capacity to fulfill PBF requirements. All of the 37 rural health centers constructed under the parent Project have the necessary wiring to support both mains and solar panel generated electricity. Most of these facilities have or will be equipped with solar panels under the current Project. Under the AF2, solar panels will be procured and installed in the remaining eleven health facilities.

COMPONENT 3: Project Management, Coordination and Monitoring & Evaluation (US$1.95 million AF2, of which Gavi co-financing US$0.37 million)

21. **There are no changes to the scope of this component under the AF2**. This component will finance incremental operating costs and limited replacement of office equipment and furniture for the PCG, services, workshops, and training for the Project implementation staff, at central, regional and district levels, monitoring and evaluation, and Project audits. A regional office in GBAO may be established depending on the selection of the additional project districts.

E. Implementation

Institutional and Implementation Arrangements

22. The institutional arrangements will remain the same as under the original Project. Therefore, activities to be undertaken under this AF would be executed under the direction of the MoHSP PCG. The PCG consists of MoHSP technical, fiduciary, administrative staff, and local consultants at the central level who manage implementation of Project activities, including M&E. Similar arrangements already in place in the Khatlon and Sogd Oblast (regional) health departments, will continue under the proposed AF. The proximity of Khatlon and RRS oblasts to Dushanbe will make it possible for the PCG to closely monitor and support the implementation of activities. The PCG will also support the implementation of activities in two districts in GBAO, with a potential opening of a regional office there depending on the selection of the additional project districts. Implementation of the citizen engagement activities will be done by the MoHSP public relations team in collaboration with facilitators from local NGOs. The implementing agency capacity and technical expertise have improved over the last two years, and it is, therefore, well positioned to utilize additional resources, as well as implement activities in the proposed new districts. Capacity building activities, such as training and technical assistance for the new districts, were discussed during appraisal to ensure that they will catch up with other districts on implementation as soon as the AF becomes effective. The full details on operational procedures that guide Project implementation are outlined in the Project Operations Manual (POM), adopted by Order #671 of the MoHSP on November 18, 2013. The POM has been updated to include the AF2 activities. Adoption of the amended POM by the Recipient in a manner acceptable to the Association would be a condition for the AF2 Project Effectiveness.

Fiduciary

23. Procurement. The procurement implementation arrangements would remain the same as under the original Project. Procurement activities will be carried out by the MoHSP through the existing PCG. The PCG has engaged the services of procurement consultants who work in close collaboration with the MoHSP procurement staff who have gained significant experience and participated in various procurement trainings. Overall procurement capacity for the implementation of procurement under the AF is assessed as Satisfactory.

24. Financial Management. The financial management responsibilities for the AF2 would remain with the MoHSP's PCG, which was established in November 2012 to implement the World Bank-funded projects, namely the HSIP and the AF2, the Health Institutional Development Fund Grant, and the Japan Social Development Fund Grant. The MoHSP's PCG has gained the required capacity in implementing partner-funded projects, it is adequately staffed, and appropriate controls and procedures have been instituted. The financial management assessment has confirmed that there are overall adequate financial management arrangements in place at the MoHSP for implementation of the AF2. There will be no major change in financial management and disbursement arrangements for the AF2, with the only change relating to the Designated Account that is proposed to be opened in a commercial bank acceptable to the World Bank. Delays encountered in processing currency conversion and payment transactions through the Ministry of Finance Treasury system under the AF1 to the parent Project, and

the foreign exchange losses that have occurred due to delays in processing transactions from the Treasury side, justify the use of a commercial bank, acceptable to the World Bank, for the AF2 in order to facilitate the timely completion of Project activities.

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F. Project location and Salient physical characteristics relevant to the safeguard analysis (if known)

The second Additional Financing to HSIP would support installation of solar panels at eleven Rural Health Centers constructed under the original Project in the Sughd and Khatlon Oblasts (regions) of Tajikistan to ensure dependable electricity supply and minor rehabilitation of selected primary care facilities in new Project districts.

G. Environmental and Social Safeguards Specialists on the Team

Suryanarayana Satish, Social Specialist
Hmayak Avagyan, Environmental Specialist

SAFEGUARD POLICIES THAT MIGHT APPLY

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	Environmental issues related to installation of solar panels at RHCs and rehabilitation of healthcare facilities and waste management (construction debris and asbestos) necessitate triggering OP 4.01.
Performance Standards for Private Sector Activities OP/BP 4.03	No	N/A
Natural Habitats OP/BP 4.04	No	N/A
Forests OP/BP 4.36	No	N/A
Pest Management OP 4.09	No	N/A
Physical Cultural Resources OP/BP 4.11	No	N/A
Indigenous Peoples OP/BP 4.10	No	There are no Indigenous Peoples, as defined in OP 4.10, in the project areas.
Involuntary Resettlement OP/BP 4.12	No	Civil works will take place on the existing footprint of these facilities and the project will not finance any activities that will result in land acquisition, and/or restriction in access to physical assets, resources or services.

Safety of Dams OP/BP 4.37	No	N/A
Projects on International Waterways OP/BP 7.50	No	N/A
Projects in Disputed Areas OP/BP 7.60	No	N/A

KEY SAFEGUARD POLICY ISSUES AND THEIR MANAGEMENT

A. Summary of Key Safeguard Issues

1. Describe any safeguard issues and impacts associated with the proposed project. Identify and describe any potential large scale, significant and/or irreversible impacts:
Physical works to be supported by the proposed AF will be limited to installation of solar panels at eleven Rural Health Centers (RHC) within the existing footprint of these facilities and minor rehabilitation of selected primary care facilities in new Project districts. These works will generate only minor environmental impacts such as noise, dust and construction waste, along with some occupational health and safety risks. Older building structures may contain asbestos, which would require sound management during dismantling and disposal. Hence, the environmental category, given to the project in accordance with OP 4.01 Environmental Assessment, remains Category B, and no additional safeguard policies are triggered.

2. Describe any potential indirect and/or long term impacts due to anticipated future activities in the project area:
Following are potential indirect and/or long term impacts due to anticipated future activities in the project area:-

(i) Localized soil and water contamination due to poor sanitation and inadequate waste management.
(ii) Toxic air emissions due to poor incineration/burning practices of unsegregated waste.
(iii) Contamination due to poor management of construction waste and indiscriminate disposal of asbestos.
(iv) No such impacts with regard to social safeguards.

3. Describe any project alternatives (if relevant) considered to help avoid or minimize adverse impacts.
The project will not finance any activities that will result in land acquisition, and/or restriction in access to physical assets, resources or services.

4. Describe measures taken by the borrower to address safeguard policy issues. Provide an assessment of borrower capacity to plan and implement the measures described.
ESMF, prepared for the purposes of the first AF, has been updated to reflect the proposed AF components. Environmental and Social Management Framework (ESMF) will be applied to address minor environmental impacts associated with the noise, dust and construction waste, along with some occupational health and safety risks. The proposed AF rehabilitation of buildings may include the dismantling and disposal of asbestos, and management provisions are included in the ESMF. ESMF provides guidelines for designing site-specific ESMPs, including necessary mitigation and monitoring measures, and organizational and implementation arrangements. Site-specific ESMPs will be prepared and approved when the detailed designs are available and prior to commencement of civil works and mobilization of equipment to the site. The ESMP requirements, including regular supervision of environmental and social performance will be included into the civil works bidding documents. The Borrower has shown satisfactory track record in environmental and social performance throughout the life of Project. Site-specific ESMPs developed for all

facilities are compliant with the Bank's requirements.

5. Identify the key stakeholders and describe the mechanisms for consultation and disclosure on safeguard policies, with an emphasis on potentially affected people.

The project's main beneficiaries are the general population and specifically, women and children. The stakeholders will include healthcare workers, and staff from the MOHSP and the RHCs, the construction management agencies which will be involved in providing clearances and undertaking the civil works, the neighborhood communities residing near the RHCs and those who utilize the services of the RHCs and primary care facilities.

The MOHSP has translated and re-disclosed an ESMF updated for the purposes of the second AF on their website on October 10, 2019. Because the nature and the scope of activities will not change as a result of the re-structuring, it was agreed with the regional safeguards adviser (RSA) that public consultations are not required for the updated ESMF. The ESMF was submitted to InfoShop on October 10, 2019.

Site-specific ESMPs will be disclosed at the Oblast Health Departments. Brief information on the planned civil works and contact information for addressing questions and grievance will be placed at the work site and/or in its immediate surroundings.

There are no persons who will be affected by Involuntary Resettlement. The project will focus on poorer rural women as a major beneficiary group through emphasis on maternal health services in the Primary Health Center facilities in undeserved areas in the country.

On the supply side, focus on improving nurse training and post-graduate experience would also target women in the area of service delivery, as the majority of nurses in Tajikistan are women. Children and infants are also a specific target beneficiary group. The Project Development Objective indicators show the strong focus on outcomes related to children's health. The focus on undeserved rural areas will directly target children from poorer families. Improved child health will have a direct positive impact on benefiting women who are the primary care givers, as well as school attendance rates.

B. Disclosure Requirements (N.B. The sections below appear only if corresponding safeguard policy is triggered)

Environmental Assessment/Audit/Management Plan/Other

Date of receipt by the Bank	Date of submission for disclosure	For category A projects, date of distributing the Executive Summary of the EA to the Executive Directors
10-Oct-2019	10-Oct-2019	

"In country" Disclosure

Tajikistan

10-Oct-2019

Comments

ESMF re-disclosed at the MOHSP website.
Disclosure link to MOHSP website

If the project triggers the Pest Management and/or Physical Cultural Resources policies, the respective issues are to be addressed and disclosed as part of the Environmental Assessment/Audit/or EMP.

If in-country disclosure of any of the above documents is not expected, please explain why:

C. Compliance Monitoring Indicators at the Corporate Level (to be filled in when the ISDS is finalized by the project decision meeting) (N.B. The sections below appear only if corresponding safeguard policy is triggered)

OP/BP/GP 4.01 - Environment Assessment

Does the project require a stand-alone EA (including EMP) report?
Yes
If yes, then did the Regional Environment Unit or Practice Manager (PM) review and approve the EA report?
Yes
Are the cost and the accountabilities for the EMP incorporated in the credit/loan?
Yes

The World Bank Policy on Disclosure of Information

Have relevant safeguard policies documents been sent to the World Bank for disclosure?
Yes
Have relevant documents been disclosed in-country in a public place in a form and language that are understandable and accessible to project-affected groups and local NGOs?
Yes

All Safeguard Policies

Have satisfactory calendar, budget and clear institutional responsibilities been prepared for the implementation of measures related to safeguard policies?
Yes
Have costs related to safeguard policy measures been included in the project cost?
Yes
Does the Monitoring and Evaluation system of the project include the monitoring of safeguard impacts and measures related to safeguard policies?
Yes
Have satisfactory implementation arrangements been agreed with the borrower and the same been adequately reflected in the project legal documents?
Yes

CONTACT POINT

World Bank

Kate Mandeville
Public Health Spec.

Baktybek Zhumadil
Senior Operations Officer

Borrower/Client/Recipient

Republic of Tajikistan
Mehrinamo Jonmamadova
Deputy Minister of Finance
mjonmamadova@mail.ru

Implementing Agencies

Ministry of Health & Social Protection Project Coordination Group
Mahbuba Sheralieva
Project Officer
mahbuba@hsip.tj

Ministry of Health & Social Protection
Saida Umarzoda
First Deputy Minister
sumarzoda@mail.ru

FOR MORE INFORMATION CONTACT

The World Bank
1818 H Street, NW
Washington, D.C. 20433
Telephone: (202) 473-1000
Web: http://www.worldbank.org/projects

APPROVAL

Task Team Leader(s):	Kate Mandeville Baktybek Zhumadil

Approved By

Safeguards Advisor:	Nina Chee	22-Oct-2019
Practice Manager/Manager:	Tania Dmytraczenko	22-Oct-2019
Country Director:	Lilia Burunciuc	28-Oct-2019