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Report No: PAD5177

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT
ON A PROPOSED

GRANT
IN THE AMOUNT OF SDR 29.8 MILLION
(US$ 40 MILLION EQUIVALENT)

WITH CO-FINANCING FROM
A GRANT IN THE AMOUNT OF US$ 12.50 MILLION FROM THE GLOBAL FINANCING FACILITY

AND
A GRANT IN THE AMOUNT OF US$ 4.75 MILLION FROM THE HEALTH EMERGENCY PREPAREDNESS AND RESPONSE PROGRAM TRUST FUND

TO THE

REPUBLIC OF TAJIKISTAN

FOR A

TAJIKISTAN MILLATI SOLIM PROJECT

October 2, 2023

Health, Nutrition & Population Global Practice
Europe And Central Asia Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective July 31, 2023)

Currency Unit =	TJS
TJS10.98 =	US$1
US$1 =	SDR0.74

FISCAL YEAR
January 1 - December 31

Regional Vice President:	Antonella Bassani
Regional Director:	Michal J. Rutkowski
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ABBREVIATIONS AND ACRONYMS

AMR	Antimicrobial Resistance
CHC	City Health Center
CME	Continuous Medical Education
DHC	District Health Center
DHS	Demographic and Health Survey
DRS	Districts of Republican Subordination
ECA	Europe and Central Asia
EHS	Essential Health Services
EMR	Electronic Medical Record
EPR	Electronic Patient Registry
ESMF	Environmental and Social Management Framework
FASTR	Rapid Cycle Facility Phone Survey
FM	Financial Management
GBAO	Gorno-Badakhshan Autonomous Oblast
GFF	Global Financing Facility for Women, Children and Adolescents
GRM	Grievance Redress Mechanism
GRS	Grievance Redress Service
HAU	Health Analysis Unit
HCI	Human Capital Index
HEPR	Health Emergency Preparedness and Response
HH	Health House
HNP	Health, Nutrition and Population
HSIP	Health Services Improvement Project
IBRD	International Bank for Reconstruction and Development
IDA	International Development Association
IHR	International Health Regulations
IPF	Investment Project Financing
IVA	Independent Verification Agent
LAN	Local Area Network
LMIC	Low- and Middle-Income Countries
MoF	Ministry of Finance
MoHSPP	Ministry of Health and Social Protection of Population
NCD	Noncommunicable Diseases
NHS	National Health Strategy
OOP	Out-of-pocket expenditure
PBC	Performance-based Condition
PBT	Performance-based Target
PDO	Project Development Objective
PFM	Public Finance Management
PHC	Primary Health Care
PIP	Prioritized Investment Plan
POM	Project Operations Manual
RHC	Rural Health Center
SDI	Service Delivery Indicators
SES	State Sanitary Epidemiological Service
SGBP	State Guaranteed Benefits Package
TEC-19	Tajikistan Emergency COVID-19 Project
TF	Trust Fund
ToR	Terms of Reference
TSG	Technical Support Group
UHC	Universal Health Coverage
WHO	World Health Organization

TABLE OF CONTENTS

DATASHEET

BASIC INFORMATION

Project Beneficiary(ies)	Operation Name		
Tajikistan	Tajikistan Millati Solim Project		
Operation ID	Financing Instrument	Environmental and Social Risk Classification	
P178831	Investment Project Financing (IPF)	Moderate	

Financing & Implementation Modalities

[ ] Multiphase Programmatic Approach (MPA)	[✓] Contingent Emergency Response Component (CERC)
[ ] Series of Projects (SOP)	[ ] Fragile State(s)
[✓] Performance-Based Conditions (PBCs)	[ ] Small State(s)
[ ] Financial Intermediaries (FI)	[✓] Fragile within a non-fragile Country
[ ] Project-Based Guarantee	[ ] Conflict
[ ] Deferred Drawdown	[ ] Responding to Natural or Man-made Disaster
[ ] Alternative Procurement Arrangements (APA)	[ ] Hands-on Expanded Implementation Support (HEIS)

Expected Approval Date	Expected Closing Date
24-Oct-2023	31-Dec-2028
Bank/IFC Collaboration	
No	

Proposed Development Objective(s)

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

Components

Component Name	Cost (US$)
Component 1: Quality Improvements of Primary Care through Primary Healthcare Strengthening	25,521,420.00
Component 2: Efficiency-enhancing Reforms in the PHC Network	20,417,520.00
Component 3: Health Emergency Preparedness and Response	4,750,000.00
Component 4: Project Management, Coordination, and Results Monitoring	6,561,060.00
Component 5: Contingent Emergency Response	0.00

Organizations

Borrower:	Republic of Tajikistan
Implementing Agency:	Ministry of Health and Social Protection of Population

PROJECT FINANCING DATA (US$, Millions)

Maximizing Finance for Development

Is this an MFD-Enabling Project (MFD-EP)?	No
Is this project Private Capital Enabling (PCE)?	No

SUMMARY

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

DETAILS

World Bank Group Financing

International Development Association (IDA)	40.00
IDA Grant	40.00

Non-World Bank Group Financing

Trust Funds	17.25

Health Emergency Preparedness and Response Multi-Donor Trust	4.75
Global Financing Facility	12.50

IDA Resources (US$, Millions)

	Credit Amount	Grant Amount	SML Amount	Guarantee Amount	Total Amount
National Performance-Based Allocations (PBA)	0.00	40.00	0.00	0.00	40.00
Total	**0.00**	**40.00**	**0.00**	**0.00**	**40.00**

Expected Disbursements (US$, Millions)

WB Fiscal Year	2024	2025	2026	2027	2028	2029
Annual	7.69	12.89	11.71	10.26	10.11	4.59
Cumulative	7.69	20.58	32.28	42.54	52.66	57.25

PRACTICE AREA(S)

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Governance

CLIMATE

Climate Change and Disaster Screening

Yes, it has been screened and the results are discussed in the Appraisal Document

SYSTEMATIC OPERATIONS RISK- RATING TOOL (SORT)

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

POLICY 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

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

E & S Standards	Relevance
ESS 1: Assessment and Management of Environmental and Social Risks and Impacts	Relevant
ESS 10: Stakeholder Engagement and Information Disclosure	Relevant
ESS 2: Labor and Working Conditions	Relevant
ESS 3: Resource Efficiency and Pollution Prevention and Management	Relevant

ESS 4: Community Health and Safety	Relevant
ESS 5: Land Acquisition, Restrictions on Land Use and Involuntary Resettlement	Relevant
ESS 6: Biodiversity Conservation and Sustainable Management of Living Natural Resources	Not Currently Relevant
ESS 7: Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities	Not Currently Relevant
ESS 8: Cultural Heritage	Not Currently Relevant
ESS 9: 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

Legal Covenants

Sections and Description
IDA FA,Schedule 2, Section I A (2) - Not later than thirty (30) days after the Effective Date, the Recipient shall establish and thereafter maintain throughout the period of Project implementation a Project coordination group, with mandate and composition satisfactory to the Association, and responsible for, inter alia, providing oversight, technical guidance, and policy direction to the implementation of the Project.
IDA FA,Schedule 2, Section I A (3) - Not later than ninety (90) days after the Effective Date, the Recipient shall establish and thereafter maintain throughout the period of Project implementation an inter-sectoral committee, with mandate and composition satisfactory to the Association, and responsible for, inter alia, inter-sectoral Project oversight for activities requiring inter-sectoral collaboration.
IDA FA,Schedule 2, Section I A (4) - Not later than thirty (30) days after the Effective Date, the Recipient shall: (a) configure the accounting software in use at MoHSPP to support the scope of the Project; and (b) recruit two procurement specialists, a financial management specialist, and two disbursement specialists; all with qualifications, experience, and terms of reference satisfactory to the Association and thereafter maintain such positions throughout the Project implementation period.
IDA FA,Schedule 2, Section I C (i) - Appoint, not later than 3 months after the Effective Date, and thereafter maintain throughout Project implementation, an independent verification agent, under terms of reference satisfactory to the Association ("Independent Verification Agent" or "IVA"), which shall include such agent's obligation to verify achievement of the PBTs.
ESCP 1.1 b) - Hiring one environmental specialist and one social development specialist within two months after the effectiveness.

Conditions

Type	Citation	Description	Financing Source

Effectiveness	Article IV,4.01(a)(b)	The GFF and HEPR Grant Agreements have been executed and delivered and all conditions precedent to its effectiveness or to the right of the Recipient to make withdrawals under it (other than the effectiveness of IDA Financing Agreement) have been fulfilled.	IBRD/IDA
Effectiveness	Article IV,4.01(c)	The Recipient has developed and adopted the POM satisfactory to the Association.	IBRD/IDA
Effectiveness	Article IV,4.01(d)	The Recipient has appointed a Project Director, 2 Project Deputy Directors, and a Project Coordinator all with terms of reference and qualifications acceptable to the Association.	IBRD/IDA
Effectiveness	Article IV,4.01(e)	The Recipient has established the Technical Support Group (“TSG”) in a manner satisfactory to the Association.	IBRD/IDA
Effectiveness	Article V,5.01	The Financing Agreement has been executed and delivered and all conditions precedent to its effectiveness or to the right of the Recipient to make withdrawals under it (other than the effectiveness of this Agreement) have been fulfilled.	Trust Funds

I. STRATEGIC CONTEXT

A. Country Context

1. **Tajikistan is a lower-middle-income International Development Association (IDA) member country in Central Asia with a large proportion of the population vulnerable to external economic shocks.** The landlocked country has a population of 9.8 million.[1] From 2012 to 2021, the economy grew at a robust average rate of 7 percent per year. Nevertheless, as of 2022, with a gross domestic product (GDP) per capita (current US$) of US$1,054.2 Tajikistan remained the poorest country in the World Bank's Europe and Central Asia (ECA) region.[2] The economy is highly vulnerable to external shocks, relying heavily on primary commodity production and exports. While the country is projected to continue to grow at about 4.5 to 5 percent per year over the medium term, according to the World Bank projections[3], limited fiscal space will be further constrained by infrastructure-related spending planned over the next decade. The country needs to broaden its tax base to increase critical investments in health, education, and social protection.[4]

2. **While Tajikistan has achieved sustained progress in reducing poverty, high population growth and low economic productivity continue to pose substantive challenges for poverty reduction and public service delivery.** The poverty rate fell from 32 percent in 2009 to an estimated 14.6 percent in 2021 (at the international poverty line of US$3.65 a day, 2017 PPP).[5] Underemployment and informality (half of the labor force is informal[6]), low productivity, and a high dependency ratio contribute to a high prevalence of poverty in Tajikistan. About 70 percent of the population live in rural areas. Rural and remote areas are significantly poorer than urban settings on average, and face highly volatile incomes compounded by strong seasonality. Service delivery is challenged by a mountainous terrain, which accounts for 93 percent of the landlocked country. Progress on poverty reduction and service delivery are compounded by rapid population growth, which, at 2.3 percent as of 2020, is the highest in the ECA region.

3. **Tajikistan is prone to natural disasters such as droughts, earthquakes, landslides, and floods, which can disrupt healthcare services. Climate change is exacerbating natural disaster risks and lead to extreme temperatures and an increase in heat-related illnesses, such as heatstroke and dehydration.** Tajikistan's steep mountainous terrain makes it highly susceptible to natural hazards. From 1992 to 2016, natural disasters affected 7 million people – more than 80 percent of the total population – and caused economic losses worth US$1.8 billion.[7] As these events cause disruptions in infrastructure – for example, transportation and sanitation systems – and lead to an increase in the number of displaced people that live in temporary shelters, they increase the risk for disease transmission and outbreaks.

4. **Tajikistan's human capital index (HCI) score of 0.5 reflects the urgent need for investments in human capital development.** Tajikistan's HCI score of 0.5 in 2020, indicates that a child born today in Tajikistan is expected to be 50

[1] Where not otherwise indicated, data and qualitative information in this and the following paragraphs come from either Neelsen, Sven, Farrukh Egamov, Husniya Dorgabekova, and Kate Mandeville. 2021. "Review of Public Health Expenditure in the Republic of Tajikistan: Discussion Paper." Washington, DC: World Bank; or the Tajikistan section of the World Bank Macro Poverty Outlook Europe and Central Asia – Spring Meetings 2022.
[2] https://data.worldbank.org/country/tajikistan
[3] World Bank. 2023. *Tajikistan Economic Update, Summer 2023: Focusing on Boosting Private Sector Dynamism in Tajikistan.* Washington, DC: World Bank.
[4] International Monetary Fund (IMF). 2022. "Tajikistan: Staff Concluding Statement of the 2022 Article IV Mission."
[5] World Bank. 2022. *Europe and Central Asia Economic Update, Fall 2022: Social Protection for Recovery*. Washington, DC : World Bank.
[6] World Bank. 2020. "Tajikistan: Policy Note on Informality. Declining Informality Amidst Weak Employment Growth." Macroeconomics, Trade and Investment Global Practice, Europe and Central Asia Region. https://opswork.worldbank.org/home/P170324.
[7] https://www.gfdrr.org/sites/default/files/publication/Tajikistan.pdf.

percent as productive as he or she could be if growing up with complete education and in full health. High levels of childhood stunting and poor learning outcomes are the main contributors to Tajikistan's low HCI score which puts the country below the ECA average of 0.62,[8] and regional comparators such as the Kyrgyz Republic (0.60), Kazakhstan (0.63), and Uzbekistan (0.62). Therefore, with lagging health outcomes, there is a substantive loss of human capital, which is a key driver of individual and nationwide prosperity.

B. Sectoral and Institutional Context

5. **Despite substantive progress in the last two decades, Tajikistan continues to trail other countries in the ECA region in key health indicators, such as life expectancy, child mortality, and stunting. Noncommunicable diseases (NCD) and gender-based violence (GBV) are on the rise.** Reductions in maternal and child (MCH) mortality are the main drivers of the rapid increase in life expectancy that Tajikistan saw in recent decades (Table 1). Despite these achievements, Tajikistan's health outcomes still lag those of other countries in the ECA region (Table 1). Large inequities in health outcomes persist.[9] While infectious diseases continue to represent a large share of the disease burden, NCDs, such as cardiovascular disease and diabetes are steeply on the rise and are now responsible for the majority of death and disability in the country.[10] Another key challenge is the high and increasing prevalence of GBV. In the 2017 Demographic and Health Survey (DHS), despite a suspected high rate of underreporting, 31 percent of ever-married women reported experiencing domestic violence – a significant increase over the previous 2012 DHS, when the rate stood at 19.5 percent.

Table 1. Key Health Outcomes (latest year of available data, except for population)

Country	*Population 2019 (millions)*	*Life expectancy at birth*	*Total fertility rate*	*Under-five mortality*	*Maternal mortality*	*Childhood stunting*	*Facility deliveries*	*Effective delivery care*	*Any ANC*	*ANC initiated in first trimester*
Tajikistan	**9**	**71**	**3.6**	**32**	**17**	**15**	**89**	**51**	**94**	**68**
Kazakhstan	19	73	2.9	10	10	7	>99	84	>99	90
Kyrgyz Rep.	6	72	3.3	18	60	11	>99	80	>99	93
Turkmenistan	6	68	2.7	42	7	8	>99	72	>99	94
Uzbekistan	33	72	2.8	14	29	10	97	-	>99	74
ECA (non-HIC)	*386*	*74*	*1.9*	*11*	*18*	*8*	-	-	-	-
LMIC	*3,279*	*69*	*3.2*	*37*	*210*	*22*	-	-	-	-

Source: World Development Indicators, 2022; World Health Organization (WHO) Global Health Expenditure Database, 2021; and Health Equity and Financial Protection Indicators (HEFPI) database, 2022 edition.

6. **Inadequate access to certain services and quality of health services are the root causes of Tajikistan's lagging health outcomes.** Formally, all Tajiks are entitled to subsidized health services from public providers, with user fee exemptions for several demographic and socioeconomic groups, including the poor.[11] However, while Tajikistan has

[8] Unweighted average across ECA countries except Turkmenistan for which no data is available.
[9] For instance, the 2017 Demographic and Health Survey estimated that infant mortality stood at 9 per 1,000 live births in Dushanbe compared with 33 in Khatlon region and was over twice as high in the poorest as in the richest wealth quintile.
[10] See Vos et al. 2020. "Global burden of 369 diseases and injuries in 204 countries and territories, 1990–2019: a systematic analysis for the Global Burden of Disease Study 2019." The Lancet 396 (10258):1204-1222.
[11] Public health coverage is provided through two tax-financed benefit packages, namely the donor-supported "State Guaranteed Package of Health Services," which as of 2019 was implemented in 20 districts and the "Government Decree No. 600" in the rest of the country. The packages are similar in scope and stipulate subsidized user fees from which several population groups are exempt based on their age, social status, or health. Effective coverage under both packages is, however, weak due to supply side constraints, pervasive informal payments, and exclusion of essential outpatient drugs.

achieved high levels in utilization of key MCH services, access rates are low for NCD services, with only 13 percent of patients with hypertension and 20 percent of those with diabetes on treatment in a nationally representative survey from 2016.[12] Moreover, stark and growing regional and socioeconomic inequities even for services with high national coverage persist**.** Gaps in care quality are also pervasive[13,14], which means that effective coverage is lower. As international estimates show many deaths per year could be avoided through better healthcare access and even more through better healthcare quality.[15]

7. **Improving primary health care (PHC) service access and quality requires substantive investments in service-readiness[16] – infrastructure, equipment, supplies, and skills of healthcare workers.** Quality of care delivery in PHC is inhibited by PHC facilities not meeting minimum standards. Basic infrastructure is missing in many facilities and infrastructure quality vary substantively across regions.[17] In terms of human resources, the skills gap, emigration of critical workers, and inadequate task mix hamper PHC quality. Tajikistan, like other former Soviet countries, employs an unusually large number of healthcare workers per population – 7.3 per 1,000 inhabitants compared to the average 5.7 (2.6) per 1,000 inhabitants across all upper (lower) middle-income countries. Yet, the share of family medicine doctors (general practitioners) among all physicians remains low, particularly in rural areas. Despite efforts in recent years to train and place more family medicine doctors and strengthen their role as gatekeepers for higher levels of care, the density of family medicine doctors has decreased by 21 percent in the past seven years. Some 50 percent of all PHC facilities are run by nurses, of which many are low-skilled and not allowed to carry out many basic tasks, including giving an injection.[18] The lack of family medicine doctors is partly due to brain drain of qualified health professionals seeking better work conditions and higher pay in the Russian Federation and other countries.[19] Furthermore, only small shares of family doctors and nurses successfully passed basic knowledge tests for the diagnosis and treatment of common noncommunicable and childhood conditions, and unindicated prescription of antibiotics was common.[20,21] Thus, there are substantive gaps in clinical knowledge and practice. As a result of these challenges and the structural health system issues described below, the utilization of PHC is low as population often bypasses cost-effective primary care. Consequently, the limited available data indicate low health worker productivity. For example, the 2015 study of PHC facilities in Sughd and Khatlon showed that clinical staff saw a mere 3.8 patients per day on average.

8. **Low PHC quality also is a crucial determinant of high out-of-pocket (OOP) medical expenditures, and inefficient health sector spending. Effective PHC is urgently needed, as rapid population growth adds pressure on a healthcare**

[12] Neelsen, Sven et al. 2021. "Review of Public Health Expenditure in the Republic of Tajikistan" based on data from the 2016 WHO Stepwise Approach to Surveillance Survey.

[13] For instance, while almost 90 percent of deliveries took place in health facilities, according to the 2017 DHS, immediate breastfeeding and skin-to-skin contact between mother and child were initiated for less than half of births.

[14] Ahmed, Tashrik, Aneesa Arur, Damien de Walque, and Gil Shapira. 2019. "Incentivizing quantity and quality of care: evidence from an impact evaluation of performance-based financing in the health sector in Tajikistan."

[15] GBD 2016 Causes of Death Collaborators. Global, regional, and national age-sex specific mortality for 264 causes of death, 1980-2016: a systematic analysis for the Global Burden of Disease Study 2016. Lancet. 2017 Sep 16;390(10100):1151-1210.

[16] Service-readiness is a key component of healthcare quality, which is achieved if a facility has the basic infrastructure/amenities, essential equipment and medicines, and the healthcare workers with the required skills to provide basic PHC interventions relating to reproductive, maternal and child health, and infectious and noncommunicable diseases. Source: *Global efforts in measuring quality of care*. Geneva: WHO.

[17] For example, a 2015 survey of Health Houses and Rural Health Centers show that in Khatlon, only half of the Rural Health Centers had access to clean water and 20 percent lacked a functioning toilet, while in Sughd, 83 percent of Rural Health Centers had clean water and only eight percent had no toilet.

[18] WHO. 2023. Health Workforce Labor Market Assessment. Draft Report. Unpublished.

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

[20] See also Kaae, S., Lilit Ghazaryan, Karaman Pagava, Irma Korinteli, Larissa Makalkina et al. 2020. "The antibiotic knowledge, attitudes and behaviors of patients, doctors and pharmacists in the WHO Eastern European region - a qualitative, comparative analysis of the culture of antibiotic use in Armenia, Georgia, Kazakhstan, Moldova, Russia and Tajikistan." *Research in Social & Administrative Pharmacy (RSAP)* 16 (2): 238–248.

[21] Prytherch, H., Renato L. Galeazzi1, Mouazamma Djamalova, Nargis Rakhmatova, Zukhra Kasymova et al. 2018. "Improving the quality of Primary Health Care through the reform of Medical Education in Tajikistan." *Public Health Panorama* 04 (04): 599–605. WHO.

system already struggling to meet demand. The low quality of PHC facilities leads patients to self-medicate and overuse specialist and inpatient care as well as drugs,[22] causing not just a severe misallocation of public health sector spending but also substantive OOP medical spending risk in the population. In 2019, the OOP share in total health spending stood at 71 percent (Table 2) and 10 percent of the population experienced "catastrophic" OOP payments exceeding 10 percent of their household budget. Most OOP spending goes to medicines and medical devices, and informal payments to healthcare workers remain common.[23] The need to increase domestic financing for the health sector and improve the quality of, and stimulate demand for, cost-effective PHC services is particularly urgent in light of the rise in NCDs and rapid population growth – 2.3 percent (or about 225,400 additional people in 2021) compared with a 0.1 percent ECA average.

Table 2. Health Financing Indicators, 2019

Country	Health spending		Public spending on health					OOP share of health spending
	Per capita (US$)	Share of GDP	Per capita (US$)	Share of government spending	Share domestic government	Share SHI	Share external	
Tajikistan	**62**	**7**	**18**	**6.9**	**96**	**0**	**4**	**71**
Kazakhstan	273	3	164	8.3	100	0	0	34
Kyrgyz Republic	62	4	33	7.4	81	15	4	46
Turkmenistan	500	7	90	8.7	100	0	0	77
Uzbekistan	99	6	41	8.3	100	0	0	58
ECA average (non-HIC)	*411*	*7*	*220*	*9.8*	*68*	*31*	*1*	*45*
LMIC average	*133*	*5*	*76*	*8.8*	*73*	*14*	*14*	*37*

Source: WHO Global Health Expenditure Database, 2021.

9. **The COVID-19 pandemic showed that Tajikistan also requires substantive investments to strengthen its capacity for adequate prevention and management of health emergencies.** The pandemic revealed critical gaps in the national health emergency preparedness and response (HEPR) capabilities, including the state of infrastructure, such as laboratories as well as skills of healthcare workers in emergency preparedness. These weaknesses are reflected in the Joint External Evaluation of International Health Regulations (IHR) Core Capacities of the Republic of Tajikistan Report (2019)[24] and similar assessments, including e-SPAR (State Party Self-Assessment Annual Reporting). In the 2021 Global Health Security (GHS) Index, Tajikistan ranks 140th out of 195 countries with an index score of 29 out of 100 (overall global average is 39) with vulnerabilities in prevention, detection and reporting, rapid response and health systems pillars.[25,26] The State Service for Sanitary and Epidemiological Surveillance (SES) under the Ministry of Health and Social Protection of Population (MoHSPP) is responsible for prevention and management of all health emergencies. However, over time, MoHSPP and SES have been losing trained staff, while technology and infrastructure have become obsolete. Only five percent of public health spending is allocated to the SES. In 2022, under the MoHSPP, a national public health operating center was also established to support health emergency response that needs financial support. Additionally,

[22] Donadel, M., Gulzira Karimova, Ruslan Nabiev, and Kaspar Wyss. 2016. "Drug prescribing patterns at primary health care level and related out-of-pocket expenditures in Tajikistan." *BMC Health Services Research* 16: 556.

[23] Roughly 80 percent of OOPs are used for medicines and medical devices. See Neelsen, Sven et al. 2021. "Review of Public Health Expenditure in the Republic of Tajikistan."

[24] WHO. 2019. *Joint External Evaluation of IHR Core Capacities of the Republic of Tajikistan*.

[25] Among major gaps are: (i) lack of financial resources to build a sound HEPR capabilities and ensure availability of basic means for detection and response; (ii) IHR coordination, communication and advocacy; (iii) laboratory testing for detection of priority diseases and specimen referrals and transport system; (iv) functionality of muti-sectoral coordination mechanisms for public health preparedness and response and health emergency management; (v) system for activating and coordinating trained health personnel during a public health emergency; and (vi) risk communication and addressing perceptions, risky behaviors and misinformation; and (vii) points of entry.

[26] Nuclear Threat Initiative and Johns Hopkins Center for Health Security. 2021. Retrieved from Tajikistan-1.pdf (ghsindex.org).

establishment and development of vertical programs (see below) have led to disintegration of national surveillance and prevention systems and weakened the mandate and scope of SES at both national and subnational levels.

10. **Investments in infrastructure, equipment and human resources alone are not sufficient to prepare the Tajik healthcare system for future challenges. The health sector needs structural reforms.** The way a country finances health care influences how well its health system performs in terms of quality, equity, and efficiency. Almost all health services in Tajikistan are provided through the public sector (the private sector is small and mainly in the large cities), which is financed almost exclusively through local taxes and other levies from the central budget. While administration and revenue collection are largely decentralized, central planning and norms dominate decision-making and financing at the local and facility levels. Additional structural reforms are critical to address financing inefficiencies and inequities, fragmentation of financing due to the lack of integration of vertical programs, and data for evidence-based decision-making, as explained below:

- **Health financing inequities and inefficiencies:** The allocation of public funding for health remains predominantly input-based, with facility budgets largely determined by historic staffing norms and numbers of hospital beds.[27] As the norms are outdated and not aligned with changes in the distribution and health needs of local populations, the input-based allocation mechanism results in substantial regional inequities in per capita public health care spending. Input-based financing also tweaks funding and healthcare use toward costly hospital specialized care while cost-effective primary care remains woefully underfunded and underused even if this is needed to treat the growing NCD burden. Input-based financing paired with protected line items greatly diminishes local authorities' and healthcare providers' ability to address staffing issues and make investment decisions that are efficient and aligned with the health needs of the population.

- **Fragmentation of financing due to lack of integration of vertical programs.** PHC services are provided under a locally funded and administered district (DHC) or city health centers (CHC), as well as rural health centers (RHC) and health houses (HH). In 2017, about 70 percent of the PHC network applied family medicine principles. Still, a large part of what would usually be part of a PHC benefit package – reproductive health, integrated management of childhood diseases, immunization – are provided *vertically* by specialized republican centers which are financed and operated by the central government (vertical programs) with support from development partners (DP). These vertical programs lack integration – have separate reporting and data collection systems – which leads to fragmentation of financing, duplication of service delivery and data systems, and undermines the continuity and coordination of care. One of the goals of the 2010–2020 National Health Strategy was to integrate PHC services delivered by various specialized care centers into PHC facilities. However, implementation has been limited.

- **Limited digitalization.** Documentation and data transmission are still predominately paper-based in the Tajik health sector. Within each local health system (DHCs and their subordinate RHCs and HHs), facility-level statistical reports are periodically submitted in paper form to DHCs for entry into an outdated District Health Information System (DHIS). There are hundreds of reports to fill out manually, and this is time-consuming for healthcare workers. The DHIS data widely vary in quality and do not allow for disaggregation to the patient or facility level. Therefore, data availability for evidence-based and timely decision-making for PHC is severely limited. There is no space where patient data is stored to facilitate decision-making on the management of the patient's health.

[27] In Tajikistan, PHC facilities are paid according to the "per capita financing policy." Unlike capitation elsewhere, the policy, however, does not assign funding according to the size and epidemiological and demographic profile of catchment area populations. Instead, funds are allocated according to input norms, with almost 90 percent being determined by staffing levels. The per capita financing policy merely provides a subsidy to a small share of facilities for whom the input-based budgets, when divided by the catchment area population, fall under a very low per capita threshold.

11. **Domestic funding for the health sector is inefficient and fragmented to finance primary care.** In 2019, the health share in total domestic government spending was 6.9 percent – the lowest share among Central Asian peers and substantively below the 9.8 and 8.8 percent average spending shares across ECA and low- and middle-income countries (LMIC) countries, respectively (Table 2). In 2019, public healthcare spending from domestic sources amounted to US$18 per capita, of which just about US$6.40 (36 percent) went to PHC – far below the US$59 per capita estimated to be required for effective PHC in lower-middle-income countries.[28] Public health funding remains fundamentally below the levels required to enable the provision of quality care to a growing population with increasingly complex health needs and to ensure adequate preparedness and management of future health emergencies.

12. **While progress on healthcare reform has been slow in Tajikistan, the COVID-19 pandemic has created a sense of urgency and momentum among key stakeholders to hasten progress towards universal health coverage (UHC).** Since the mid-2000s, the Government of Tajikistan has confirmed its commitment to a wide array of health system reforms in various policy documents.[29] However, reform implementation has been lagging, particularly in health financing. The COVID-19 pandemic demonstrated the consequences of reform inertia and underinvesting in the health sector, both in terms of economic impact and human suffering. At the same time, the success of the national COVID-19 vaccination program has shown the potential of results-focused collective action, spearheaded by the MoHSPP, in the health sector. This has galvanized support both from domestic and international stakeholders in Tajikistan, as stipulated in the "Strategy on Healthcare of Population of the Republic of Tajikistan up to 2030" (NHS 2030), to modernize the PHC system to build a health system that is cost-effective, patient centered, and flexible to respond to unexpected challenges. There is also renewed interest by the Government of Tajikistan in revising and implementing the Law on Health Insurance, which was adopted in 2008. Thus, there is a window of opportunity to advance on critical healthcare reforms, particularly to improve efficiency and quality of service provision for the benefit of the Tajik people.

C. Relevance to Higher Level Objectives

13. **The Project will contribute to the government's overall strategic objective of human capital development, stated in the "National Development Strategy of the Republic of Tajikistan for the period of 2030"** (NDS 2030). It has been designed to support the implementation of the recently adopted National Health Strategy 2030 (NHS 2030) and the Prioritized Investment Plan (PIP), a costed implementation plan for the NHS 2030,[30] that focuses on four focus areas – PHC, health financing, human resources, and information systems and digitalization. It details costed priority activities for each area financed by Government or DPs. The PIP serves as the main instrument in the sector to ensure complementarity and coordination in government and partner financing and is aligned with national processes, such as the Joint Annual Review of the sector, for tracking progress on implementation of NHS 2030.[31] The proposed Project activities align with the recommendations for implementing the Law on Health Insurance[32] produced by recent reviews of the Law by the World Bank and WHO, as well as the needs identified by a high-level national working group tasked with the revisions and

[28] Stenberg, K., Odd Hanssen, Melanie Bertram, Callum Brindley, Andreia Meshreky, Shannon Barkley et al. 2019. "Guideposts for investment in primary health care and projected resource needs in 67 low-income and middle-income countries: a modelling study." The Lancet Global Health 7: e1500–10.

[29] These include, for instance, National Health Strategy of the Republic of Tajikistan 2010-2020; National Development Strategy of the Republic of Tajikistan for the period up to 2030; and Strategic Plan on Health Financing Reform in the Republic of Tajikistan for the period 2019-2021.

[30] The PIP has been developed through an inclusive process led by the government (Ministry of Finance (MoF) and MoHSPP). This process is supported by all development partners in the country and the Global Financing Facility for Women, Children and Adolescents has financed most workshops held by the Government to drive the process forward.

[31] The PIP was finalized in the spring of 2023 and the government has indicated the intention to adopt the final PIP by Government Order to ensure that activities are implemented.

[32] Zine Eddinne El Idrissi, M. D., and Mirja Sjoblom. 2022. "Tajikistan: Policy Note on Mandatory Health Insurance." Europe and Central Asia Region, World Bank. Unpublished.

implementation of the Law. Thus, the proposed Project will lay the foundations for the implementation of this Law, which is scheduled for 2025.

14. **The Project is fully aligned with the World Bank's twin goals, the strategy for health, nutrition, and population, as well as the global health commitments, to which it contributes, as well as the 2019-23 World Bank Country Partnership Framework (CPF).** By investing in PHC in the poorest areas, while simultaneously introducing efficiency-enhancing structural reforms to the healthcare system in the area of financing and digitalization, the Project will support Tajikistan's efforts to achieve UHC, and, thereby, SDG target 3.8, through a stronger PHC system and to provide quality, affordable health services to everyone, regardless of their ability to pay. The Project directly contributes to the second objective of the CPF, "Enhancing Health Services", but also overall to Pillar 1 (Building Human Capital and Strengthening Social Resilience) and Pillar 2 (Improving Public Institutions and Fiscal and Environmental Sustainability). It was designed to not overlap with existing operations,[33] and, therefore, has limited focus on nutrition beyond the PHC level.

15. **The proposed Project is aligned with the goals of the Paris Agreement on mitigation and adaptation.** Tajikistan's updated National Determined Contribution (NDC) outlines its commitments to not exceed 50-60 percent of greenhouse gas emissions as of 1990 by 2030.[34] The rehabilitation of PHC centers to be financed by the Project to facilitate health service quality improvements will utilize energy-efficient building criteria to minimize potential emissions. The NDC additionally identifies key adaptation measures that this Project aligns to as outlined in Annex 1. This Project does not hinder the achievement of the country's climate strategies.

II. PROJECT DESCRIPTION

16. **The proposed Project will be co-financed by IDA (in the amount of SDR 29.8 million [US$40 million equivalent]), the Global Financing Facility for Women, Children and Adolescents (GFF; a GFF country program grant of US$2.5 million [hereafter GFF] and a GFF Essential Health Services (EHS) grant of US$10 million [hereafter GFF EHS]), and the Health Emergency Preparedness and Response Multi-Donor Trust Fund (HEPR TF; US$4.75 million grant).** The GFF supports low- and lower-middle income countries to accelerate progress on reproductive, maternal, newborn, child and adolescent health, and nutrition (RMNCAH-N) and strengthen financing and health systems for UHC. The GFF supports government-led, multistakeholder platforms to develop and implement a national, prioritized health plan (the PIP in the case of Tajikistan), that aims to help mobilize sustainable financing for health and nutrition. The GFF Trust Fund, hosted by the World Bank, links moderate amounts of resources to World Bank financing, and supports countries to strengthen their focus on data, quality, equity, results, and domestic resources for health. Recognizing the global nature of health emergencies, in June 2020, the World Bank Board approved the creation of a new umbrella trust fund program, the HEPR Program.[35] The Republic of Tajikistan has been allocated a HEPR Multi-Donor Trust Fund grant in the amount of US$4.75

[33] These include the Tajikistan Emergency COVID-19 Project (P173765), Strengthening Resilience of the Agriculture Sector Project (SRASP) (P175952), Early Childhood Development to Build Tajikistan's Human Capital Project (P169168), Tajikistan Socio-Economic Resilience Strengthening Project (P168052), Rural Water Supply and Sanitation Project (P162637), and Resilient and Sustainable Tajikistan Development Policy Operation (P177930).
[34] Updated National Determined Contribution. 2021. https://www.fao.org/faolex/results/details/en/c/LEX-FAOC210286/.
https://unfccc.int/sites/default/files/NDC/2022-06/NDC_TAJIKISTAN_ENG.pdf.
[35] The development objective of the Program is to support eligible countries and territories to improve their capacities to prepare for, prevent, respond, and mitigate the impact of epidemics on populations. It was set up as a flexible mechanism to provide catalytic, upfront, and rapid financing at times that other sources of funding are not available for health emergency preparedness, and to fill specific gaps in terms of health emergency responses. Activities eligible for HEPR Program financing focus on two pillars: (1) preparedness for future health emergencies, and (2) responses to emerging and current health emergencies. The HEPR TF anchors the HEPR Program.

million to strengthen health emergency preparedness, on the condition that these TF resources are not used to purchase COVID-19 vaccines.

A. Project Development Objective

PDO Statement

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

PDO Level Indicators

18. Five PDO-level indicators will be used to measure the attainment of the PDO as follows:

Table 3. PDO elements and indicators

PDO Elements	PDO Indicators
Quality of PHC services	1. Number of people residing in catchment areas of service-ready* district and city health centers.
	2. Number of people residing in catchment areas of service-ready rural health centers.
	3. Number of outpatient contacts with service-ready PHC facilities.
Efficiency of PHC services	4. Percent of district and city health centers** in pioneer regions contracted.
Capacity to respond to health emergencies	5. Percent of health alerts generated by routine or immediate reporting that receive initial investigation within 72 hours.***

* Service-readiness index scores will be used to distinguish facilities into service-ready and non-service-ready PHC facilities. Specific indices are being developed for (i) DHC/CHC and (ii) RHC according to their specific functions.
** Including both public and private providers.
**Activities under PDO Element 3 are funded by the HEPR TF, thus, the PDO indicator corresponds to the requirements of the HEPR Monitoring and Evaluation (M&E) Framework.

B. Project Components

19. **The proposed Project has five components that will contribute to the achievement of the PDO.** Annex 2 presents a detailed description of the Project components, including the selection of the districts/regions for Components 1 and 2. Annex 3 provides an overview of the components by sources of financing.

Component 1: Quality Improvements of Primary Care through Primary Healthcare Strengthening (Total US$25.5 million: US$18.0 million from IDA, US$7.3 million from GFF EHS, US$0.2 million from GFF)

20. **The objective of this component is to improve the conditions for delivering quality PHC services by making PHC facilities service-ready.** It will prioritize 16 districts with the highest poverty level as the Project financing envelope is insufficient to cover all districts in the country. However, support to policy development under Component 1 will be at the national level. Specifically, the objective of Component 1 will be achieved through investments in service delivery capacity – human resources, infrastructure, and equipment and in interventions to ignite the demand for PHC services among the population, including health promotion.

Subcomponent 1.1: Quality Improvements of Primary Care through Investments in Human Resources and Demand Stimulation (Total US$7.8 million: US$4.6 million from IDA, US$3.0 million from GFF EHS, US$0.2 million from GFF)

21. **Subcomponent 1.1 will address the pressing need to invest in human resources working at the PHC level.** This will be achieved by reviewing existing retention policies, and on that basis, develop and submit for the approval of the

Government, proposals for strengthening the capacity and retention of family medicine doctors and nurses in rural areas, which are also most sensitive to climate change impacts, including, but not limited, to asymmetric salary increase. These proposals will include ideas about how to optimize the PHC workforce, including potential upskilling of nurses. The subcomponent will support the implementation of identified PHC workforce retention and optimization roadmap in the 16 selected districts, including measuring the effectiveness of retention strategies. The Project will build skills among PHC staff in these districts through: (i) six-month in-person training of doctors and nurses in family medicine; (ii) PHC management training; (iii) development and establishment of a national online platform for delivery of continuous medical education (CME) for PHC providers; and (iv) technical assistance (TA) to revise the specialty standards and curricula for specialists working at the PHC level as well as to develop and integrate new training modules on GBV, antimicrobial resistance (AMR), and climate change. For the delivery of training, this subcomponent will support the Republican Clinical Training Center, including its six regional branches, with rehabilitation of their offices, and office equipment for their staff, as well as simulation centers to improve training of doctors and nurses. This subcomponent will support demand-side investments and citizen engagement (CE) activities to improve uptake of PHC services, including for RMNCHA-N services. Such demand-side interventions will include mobile outreach to citizens through Mobile Engage[36] and other health promotion activities. The activities will also include raising citizens' awareness of climate-sensitive diseases as well as MoHSPP's online Grievance Redress Mechanism (GRM). Additionally, a yearly phone-based National Patient Survey to measure citizens' views and satisfaction with healthcare services at the PHC level will be financed. This subcomponent will support the integration of GBV services in the health sector with a particular focus on PHC level through a three-pronged approach described in Annex 2.

22. This subcomponent will finance goods, works, non-consulting services, international and local TA, and training.

Subcomponent 1.2: Quality Improvements of Primary Care through Physical Infrastructure Improvements (Total US$17.7 million: US$13.4 million from IDA and US$4.3 million from GFF EHS)

23. **Subcomponent 1.2 will support improvements in physical and digital infrastructure of PHC facilities** through investments in rehabilitation of existing and, where needed, construction of new priority PHC facilities in the 16 selected districts, including the provision of basic medical/laboratory and computer equipment. Support under this subcomponent will focus on RHCs and a limited number of DHCs/CHCs, which collectively cover the predominant share of the population in the districts' catchment areas. This subcomponent aims at making facilities service-ready to deliver quality PHC services and fulfill the requirements for accreditation. By ensuring that PHC staff have good working conditions, these investments will contribute to improving the quality of front-line PHC services, making it more attractive for health workers to work at the PHC level and for citizens to visit the facilities. It will also support the development of an evidence-based concept of providing mobile PHC services to the populations in remote areas and the implementation of the concept in the 16 districts. The subcomponent will finance (i) a study of heating and lighting for rural PHC facilities; (ii) the preparation of standard designs for PHC facilities; (iii) site surveys and associated studies at the PHC facility; (iv) quality assurance of civil works; (v) costs related to obtaining permits and/or legal documentation for PHC facilities; (vi) basic medical and/or laboratory equipment and medical and/or office furniture for PHC facilities; (vii) solar panels and other alternative energy sources; (viii) computer and office equipment; and (ix) provision of mobile PHC services for remote districts. This subcomponent will finance works, goods, international and local TA, and training.

Component 2: Efficiency-enhancing Reforms in the PHC Network (Total US$20.4 million: US$15.6 million from IDA, US$2.6 million from GFF EHS, US$2.2 million from GFF)

[36] Mobile Engage is an SMS-based platform, initially supported by the World Bank through the Korea Trust Fund for Economic and Peace-Building Transitions, for broad communication to the citizen. It was successfully used during the COVID-19 pandemic to inform the public about COVID-19 risks. Mobile phone coverage rates are above 90 percent even in rural areas of Tajikistan.

24. **Component 2 supports efficiency-enhancing reforms in the PHC network, including laying the foundations for strategic purchasing and digitalization of PHC.**[37] All interventions under this component will be conceptualized for nationwide implementation and executed in two pioneer regions (Dushanbe city and Sughd region), even though digitalized facilities outside of the pioneer regions will be able to connect to the new digital systems during the Project period. Component 2 will contribute to financial sustainability of the overall health sector. This component will use Performance-Based Conditions (PBCs) to strengthen the Project's results orientation and to incentivize efficiency-enhancing reforms.[38]

Subcomponent 2.1: Strategic Purchasing of PHC Services (Total US$8.1 million: US$5.3 million from IDA, US$0.6 million from GFF EHS, US$2.2 million from GFF)

25. **Subcomponent 2.1 will build the foundation for introducing strategic purchasing in the health sector and support the establishment of a Health Services Purchasing Structure.**[39] This component will finance the establishment of a Health Services Purchasing Structure to act as a single purchaser of health care services. This includes conception of the Health Services Purchasing Structure, the creation of the legal framework as well as its establishment, initial staff costs (at the end of the Project all staffing costs will be paid by the Government), capacity building of the Health Services Purchasing Structure and equipment and furniture for the new MoHSPP building. A detailed assessment of the needed regulatory and legal changes to introduce strategic purchasing at the PHC level is currently being conducted and will inform this component.[40]

26. **The subcomponent will finance activities needed for sustainable introduction of strategic purchasing.** This includes a national domestic resource mobilization roadmap for the health sector, which is essential for the sustainability of Component 2 and to eventually implement the Law on Health Insurance. It will also finance the development and implementation of an accreditation program for PHC providers to ensure that contracted providers meet minimum quality requirements. It will finance a national PHC contracting mechanism, a change management and communication roadmap for the structural reforms, and the implementation of strategic purchasing in the pioneer regions.

27. **The subcomponent will also finance foundational activities for the introduction of strategic purchasing.** It includes the revision and costing of the national PHC benefit package and the development of a service delivery network masterplan/network optimization plan to optimize the service delivery network. It will also finance the development and implementation of a regulatory framework for the legal and regulatory changes needed to transition to strategic purchasing. It will include the deepening of the already initiated changes[41] to the Public Financial Management (PFM) systems to create more autonomy for PHC providers.

[37] Furthermore, it is foreseen that additional incentives to change the public financial management system, which is important for strategic purchasing and to increase the share of public health expenditures in relation to total public expenditure, will be introduced in the forthcoming development policy lending operations expected for FY24 and FY25.

[38] Similar incentives have been used successfully to nudge structural reforms in Tajikistan under the Early Childhood Development to Build Tajikistan's Human Capital Project (ECDP) (P169168).

[39] This is a provisional name that may change as the institution is established.

[40] The Performance-Based Targets (PBTs) related to the adoption of the regulatory framework to increase the PHC providers' autonomy and the establishment of the Health Services Purchasing Structure are only due in 2027.

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

28. This subcomponent will finance goods, non-consulting services, international and local TA, training, and eligible expenditures linked to PBCs (see below).

29. PBC 1 below is linked to subcomponent 2.1 and serves to incentivize reform implementation.[42]

- **PBC 1 – Policy and institutional reforms for introducing strategic purchasing adopted –** rewards five results: (i) national health service delivery network optimization plan developed and approved; (ii) single, state-guaranteed benefit package (SGBP) for PHC developed, costed, and approved; (iii) staffing norms for PHCs revised and approved; (iv) regulatory framework to increase the PHC providers' autonomy developed and approved; and (v) Health Services Purchasing Structure established and staffed.

Subcomponent 2.2: Digitalization and Infrastructure Upgrade of the PHC Network (Total US$12.3 million: US$10.3 million from IDA and US$2.0 million from GFF EHS)

30. **Subcomponent 2.2 will support the digitalization and infrastructure upgrades of the PHC network.** To provide reliable and quality data for capitation formula and calculation of outcome indicators, this subcomponent will finance the development and implementation of the Electronic Patient Registry (EPR), including electronic passport for citizens, and basic electronic medical record (EMR) in PHC facilities. The EPR, to be designed under the World Bank-supported Tajikistan Emergency COVID-19 (TEC-19) Project, is necessary for the implementation of the capitation formula, while the EMR system is needed to provide reliable electronic data for the calculation of outcome indicators by the purchaser. Subcomponent 2.2 will finance the implementation of the EPR and EMR in the two pioneer regions. The EPR and EMR will be developed to allow for national level scale-up, including training of healthcare workers and PHC managers in the new systems. In addition, this subcomponent will support the design, development, and implementation of the PHC management dashboard and development of business intelligence software and electronic payment systems to collect and process data from EPR, EMR, and DHIS. The PBC described below is linked to Subcomponent 2.2 and serves to incentivize reform implementation.

31. **This subcomponent will also finance infrastructure upgrades of priority PHC facilities to the level needed to meet accreditation criteria in the two pioneer regions.** This includes renovation/extension of rural and urban PHC facilities, internet access/local area networks (LAN), procurement of PHC equipment, labs, computers/tablets/smartphones, and other goods required by the accreditation program.[43] This subcomponent will also finance Business Intelligence (BI) software and the development of electronic payment systems to collect and process data from EPR, EMR, and DHIS (already used by MedStat) for analysis, reporting and payment.

- **PBC 2 – Electronic Patient Registry (EPR) and Electronic Medical Records (EMR) are functional –** will reward two results: (i) EPR is functional and integrated with the civil registry, and (ii) EMRs are functional.

32. **The disbursement of certain expenditures, approximately US$6.9 million, will be conditioned upon the achievements of targets for PBC 1 and PBC 2.** For PBC 1, the conditioned expenditures relate to the establishment and

[42] To ensure the sustainability of strategic purchasing and digitalization, there are plans to include a policy action related to increasing the share of total government expenditure (without external funding) spent on the health sector, in future development policy operations for FY24 or FY25 in Tajikistan.

[43] The difference between the infrastructure upgrades financed under this subcomponent and subcomponent 1.2 is that this subcomponent will only finance specific requests to make facilities in the pioneer regions ready to meet accreditation criteria, while Subcomponent 1.2 will make larger investments in infrastructure upgrades in the 16 target districts selected under Component 1.

operationalization of a Health Services Purchasing Structure, including equipment and furniture for the new MoHSPP building, and TA related to the development of the revised masterplan/network optimization plan.

33. **Verification of achievement of PBC targets will be conducted by an Independent Verification Agent (IVA).** The MoHSPP will hire an IVA to verify the achievement of the performance-based targets (PBT) as well as their technical merit. Terms of Reference (ToR) for the IVA will define technical criteria for each result that the IVA will verify. The contracted IVA may be an independent private, academic, or international organization that will work together with local institutions such as the Chamber of Accounts (internal auditor) to build their capacity to verify results during the Project period. Therefore, a training and TA component will be included in the ToR for the IVA. The timelines specified for the achievement of PBTs are time-bound conditions. On achievement of PBTs, the MoHSPP will submit to the World Bank satisfactory evidence that the respective PBTs have been achieved in accordance with legal agreements as may be further specified in the Project Operations Manual (POM), including corresponding eligible expenditure reports.

34. This subcomponent will finance works, goods, international and local TA, training, and eligible expenditures linked to PBCs.

Component 3: Health Emergency Preparedness and Response (US$4.75 million from the HEPR TF)

35. **Component 3 will strengthen the national HEPR capabilities in Tajikistan to improve the capacity to prevent, prepare, and respond to health emergencies.** It will finance: (i) conducting an assessment of the current capabilities of SES in the area of health emergency preparedness and response and building capacity to prevent, detect and respond to emergencies, (ii) updating job aids, standard operating procedures (SOP), and protocols, including sanitary aviation concept, (iii) developing PHC facility-level emergency plans in the 16 selected districts of Component 1; (iv) training of PHC workers in the 16 selected districts and training of epidemiologists at the national level; (v) TA to strengthen the coordination of emergency response between the PHC network and SES; (vi) the strengthening of laboratory systems of regional SES branches; (vii) training and TA to strengthen community engagement on public health-focused risk communication; (viii) TA for costing of a National Action Plan for implementation of IHR (2005), including dissemination and advocacy, (ix) upgrades of regional branches of SES and entry points, including rehabilitation and procurement of equipment; (x) procurement of a limited stockpile of emergency goods as well as items for sanitary quarantine points at the border per government-approved lists to be defined in the POM, and rehabilitation of two warehouses where the stockpile and items for sanitary quarantine points will be kept; (xi) annual simulation exercises of various types and scale; and (xii) TA to increase capacity of the MoHSPP to lead and coordinate assistance related to HEPR. Similar building standards for physical infrastructure will be used for Component 3 as in sub-component 1.2.

36. This subcomponent will finance works, goods, non-consulting services, international and local TA, and training.

Component 4: Project Management, Coordination, and Results Monitoring (Total US$6.6 million: US$6.5 million from IDA and US$0.1 million from GFF)

37. **Component 4 will finance project management, coordination, and result-monitoring.** It will also finance operating costs, project audits, verification costs of the IVA and institutional strengthening of the MoHSPP and the Ministry of Finance (MoF). The Directorate for Social Expenditures in the MoF will receive the following support: training, capacity building by local and international consultants, equipment, and operational expenditures, to adapt and implement the efficiency-enhancing reforms. The component will also finance TA and training for the establishment of a Health Analysis Unit (HAU) in the MoHSPP for the first five years of the Project; thereafter, the unit will be financed by the Government.

38. **This component will also support, at the national and sub-national levels, representative health facility surveys to collect data on quality of care. This will facilitate Project monitoring and evaluation (M&E).** The component will finance eight biannual Rapid Cycle Facility Phone Surveys (FASTR), starting in 2024 until the end of the Project period. The surveys will collect data on service-readiness and include one endline SDI survey in 2027 to gather information on a wide range of structural and process quality indicators. The baseline SDI survey in 2023/24 and the first two FASTR surveys, one in 2023 and one in 2024, will be financed by Bank-executed funding provided by the GFF. The endline SDI survey will be implemented by an independent survey firm/organization, which will be selected jointly by the MoHSPP and the World Bank. While MoHSPP remains the implementing agency for the Project-financed surveys, the MoHSPP and World Bank technical teams will work closely together on all surveys to ensure high quality of survey data.

39. This component will finance goods, non-consulting services, international and local TA, and training.

Component 5: Contingent Emergency Response (Total US$0.0)

40. **Component 5 is a Contingency Emergency Response Component (CERC) that aims to improve Tajikistan's capacity to respond to disasters**. Following an eligible crisis or emergency that may occur during Project implementation, the Recipient may request the Bank to reallocate Project funds to support emergency response and reconstruction. This component would draw from the uncommitted grant resources under the Project from other project components to cover emergency response. An emergency eligible activity is in response to an event that has caused or is likely/imminently to cause, a major adverse economic and/or social impact to the Recipient, associated with a disaster. The POM will include a specific annex for the CERC, laying out the provisions for activating and implementing the component.

C. Project Beneficiaries

41. **Project beneficiaries are Tajikistan citizens and residents who use PHC services and who benefit from the country's health emergency response system.** The beneficiaries include people of all ages, including those with or at risk of NCDs, young children, pregnant women, adolescents, elderly people, and victims of GBV. Project beneficiaries also include medical and non-medical staff of healthcare facilities, who will receive training and benefit from improved working conditions through the Project. Government officials and academia will benefit from the trainings and TA.

42. **Across Components 1 and 2, an estimated 1.8 million people, or 18% of the Tajik population, will benefit from investment in improved quality of care at their assigned DHCs/CHCs, and an estimated 320,000 people (3%) from improved quality at their assigned RHCs.** Investments in human resources, demand-side interventions, and physical infrastructure and equipment under Component 1 will benefit all the population living in the catchment areas of Project-supported facilities of the selected districts, as they will experience improved quality of primary care. These catchment area populations, supported by Component 1, amount to an estimated 700,000 for upgraded DHCs/CHCs and 180,000 for upgraded RHCs in the poorest districts in the country. Over the 2023-28 Project period, an estimated total of 13 million outpatient contacts will be handled by these facilities, including an estimated total of 31,000 children receiving vaccinations and an estimated total of 37,000 pregnant women receiving antenatal care. PHC facilities will also be upgraded under Component 2 in Sughd region and Dushanbe city to meet accreditation criteria. Combined with the implementation of strategic purchasing in these areas, this is expected to improve quality of PHC services for an estimated 2.5 million people residing in these two pioneer regions. In addition, the Project will support national-level policy development regarding the implementation of strategic purchasing and digitalization of the PHC network and capacity to respond to health emergencies (Component 3). Since policy development originating from these components will be rolled out nationwide, all Tajikistan citizens and residents, estimated at 9.8 million, will benefit from these investments, not only when a new health emergency hits.

D. Results Chain

43. The results chain is presented in Annex 4. Taken together, activities financed by the Project will improve PHC workers' skills and retention, upgrade PHC facilities, incentivize citizens to use PHC services, lay the foundation for implementing strategic purchasing and digitalization of PHC services, and strengthen the national HEPR system. These activities will contribute to outputs such as the number of trained healthcare workers with access to online learning, PHC facilities constructed/rehabilitated and equipped, the establishment of a functional Health Services Purchasing Structure, PHC facilities contracted by the purchaser in the two pioneer regions, SES laboratories that report data on priority disease, and number of annual simulation exercises completed. In turn, these are expected to lead to the following outcomes: improved access to and utilization of service-ready PHC facilities; more efficient and equitable distribution of PHC spending; more evidence-based and transparent decision-making; greater accountability for PHC financing; and strengthened national capacity to respond to health emergencies. Ultimately, over the long-term, the impact of the Project will be reflected in decreased morbidity and health-related mortality, reduced poverty, improved human capital accumulation, and a healthier nation.

E. Rationale for Bank Involvement and Role of Partners

44. **The immediate needs for the financing of the health sector and the support required to convene partners and government bodies around the NHS 2030 and PIP provide the main rationale for Bank involvement.** The government faces substantive gaps in financial capacity and the current fiscal space, and projections for the coming years, remain very tight. This is partly because of large investments needed for the Rogun hydropower plant, which has resulted in social sectors, including health, remaining underfunded. World Bank financing is essential to meet the need for capital investments and to address underfinanced areas of the health care system including PHC and HEPR. Given the limited external financing for health in Tajikistan, Project funds will play a critical role in the implementation of the NHS 2030 and the PIP. Moreover, the ability of the World Bank and the GFF partnership to combine financing and TA with critical expertise in reform areas of the Project, convening power, and trust gained from both the government and DPs because of long-standing engagement in the health sector, makes the World Bank a unique partner to support the government in implementing the crucial health financing and digitalization reforms at the PHC level.

45. **Co-financing from the GFF and the HEPR TF, and technical assistance to support the Project, highlights the critical role of partners in the Project.** Grant financing of US$12.5 million from the GFF and US$4.75 million from the HEPR TF have facilitated an expansion of the Project's initial scope to include critical reforms (Component 2) and interventions to strengthen the national health emergency response capacity (Component 3). In the future, it is hoped that additional resources can be added to the Project from the GFF and the Pandemic Fund to expand the Project's scope. Many DPs remain committed to the health sector, although some donors are gradually reducing their contributions. Technical support from other DPs will be critical for the successful implementation of the Project (a mapping of envisioned donor contributions is available upon request). The DPs supporting the health sector in Tajikistan coordinate their activities through the Health Working Group under the Development Coordination Council of Tajikistan. This is an active body currently chaired by the European Union (EU) and the WHO. Additionally, the GFF-supported Inter-sectoral Working Group (IWG), co-chaired by the Deputy Minister of Finance and the First Deputy Minister of Health and Social Protection of Population, serves as the platform for DPs to coordinate with government. The IWG took charge of developing the PIP and will continue to support donor coordination and monitor PIP implementation during the Project implementation period.

F. Lessons Learned and Reflected in the Project Design

46. **The design of the Project reflects lessons from analysis of prior policy interventions in Tajikistan and beyond,** including: (i) instead of exclusively relying on investment lending, it uses PBCs and linkages to forthcoming development policy lending to incentivize complex structural reforms; (ii) continuously making efforts to build technical and implementation capacity, especially when capacity constraints were recognized at the design stage; (iii) conduct analysis

of stakeholders and engage them in participatory processes and transparently in all stages of reform conceptualization and implementation, which includes moving from a Project Implementation Unit-based model of implementation to engagement with a larger set of stakeholders with close collaboration between the MoF and the MoHSPP; (iv) including activities like the development of a domestic resource mobilization roadmap in the Project to address the chronic underfunding of the health sector and for project activities to be effective and sustained over time; (v) extension of resources pooling, and provider autonomy as well as data availability for PHC to address key shortcomings of previous health financing reforms; (vi) in response to challenges with prior pilots, which created parallel health financing systems without a sound fiscal base for scaling, the proposed Project will focus on gradually enhancing the existing national financing system of pooling and capitation/output-based provider payment by working through the government system and lay out a clear path for fiscally sustainable nationwide scaling; (vii) carrying forward successful models of provider training and infrastructure and equipment investments from the Health Services Improvement Project (HSIP) (P126130); (viii) creating clarity around in-kind and financial contributions to Project implementation by the government and beneficiary local governments to ensure their commitment to the Project and its sustainability. A detailed description of Lessons Learned is available upon request.

III. IMPLEMENTATION ARRANGEMENTS

A. Institutional and Implementation Arrangements

47. **The MoHSPP will be the Project implementing agency, with day-to-day project coordination responsibility entrusted with the Directorate for Reforms, Primary Healthcare, and International Relations (DRPHCIR).** This directorate will report, through its Head, to two Project Deputy Directors - the First Deputy Minister of Health and Social Protection of Population (responsible for Component 1, 2, and 4) and the Deputy Minister responsible for SES/Chief Sanitary Doctors (responsible for Component 3 and 5), who, in turn, will report to the Minister of Health and Social Protection of Population/Project Director. To facilitate the carrying out of the activities under the Project, the Project Director shall delegate certain implementation functions during his/her absence in order to avoid any implementation delays for the Project, as will be further specified in POM.

48. **MoHSPP intra-sectoral project oversight, similar to HSIP, will be provided by the MoHSPP *Project Coordination Group* (PCG)**. This Group will be chaired by the ***Project Deputy Directors*** and will consist of heads of all relevant MoHSPP technical and supporting departments, with DRPHCIR acting as the ***PCG Secretariat***.[44] The PCG members will provide oversight, technical guidance, and policy direction for their respective component/subcomponent, with the First Deputy Minister overseeing implementation of Components 1, 2, and 4, and Deputy Minister responsible for SES/Chief Sanitary Doctor overseeing Component 3 and 5. As for HSIP, implementation will be executed by a ***Technical Support Group (TSG)***, consisting of local project implementation support personnel in adequate number and with adequate qualifications, including in regional offices, with all of them reporting to the First Deputy Minister of Health and Social Protection of Population and working in close day-to-day coordination with DRPHCIR. The TSG is responsible for the implementation of the project, including collecting and consolidating data and evaluating results. It will provide, in a timely manner, relevant information to the World Bank and, as applicable, other stakeholders on the implementation of the Project and achievement of the PBTs. The composition of the TSG is presented in Annex 5.

49. **Oversight of fiduciary functions, including procurement, financial management, auditing, and reporting, will be the ultimate responsibility of MoHSPP**, with specific expertise and support in these areas to be provided by the TSG.

[44] Each technical department will be responsible for technically leading one project component/subcomponent as follows: C1.1 - Directorate for Medical and Pharmaceutical Education, Human Resources for Health Policy and Science; C1.2 - Capital Construction Directorate; C2 Directorate of Economics and Budget Planning for Health and Social Protection (C2.1) and HAU (C.2.2); C3 - Directorate for Sanitary and Epidemiological Safety, Emergency and Emergency Care and HAU (health emergency); and C4 - Directorate for Reforms, Primary Healthcare, and International Relations (or International Relations Unit within this Directorate).

Financial management (FM) will be carried out by one full-time FM head specialist in the TSG, as well as two disbursement specialists (as needed) in close coordination with the MoHSPP Directorate for Economics and Budget Planning for Health and Social Protection. Procurement will be implemented by one procurement head specialist and one procurement specialist who have experience in international procurement and good command of written and spoken English with ToR acceptable to the Bank. Compliance with World Bank environmental and social policies will be the responsibility of the MoHSPP, with support from one social development specialist and one environmental specialist in the TSG. All reporting and oversight relationships will be summarized in the POM, which is a condition of Project effectiveness.

50. **Inter-sectoral project oversight, primarily for reform-oriented Component 2 and other activities requiring intersectoral collaboration, will be provided through an *Inter-sectoral Committee (IC)*.** It will be set up under the Government of Tajikistan, chaired by the First Deputy Prime Minister, with the Minister of Health and Social Protection of Population and the Minister of Finance as co-chairs, and consisting of relevant officials at the deputy minister level or higher.[45] The IC will also include relevant DPs working on matters related to Component 2, as specified in the ToR of the IC. DRPHCIR will act as the IC Secretariat. The IC will have the mandate to coordinate and review national health financing policy, including to consider and decide on matters of inter-sectoral nature related to Component 2. The IC will meet biannually or when called by the IC Chair or the Co-Chairs.

B. Results Monitoring and Evaluation Arrangements

51. **The TSG will lead M&E activities, assuring the tracking of progress on project activities, results, and outcomes**. Through the TSG, MoHSPP will be responsible for timely collection, validation, consolidation, evaluation and provision to the World Bank (prior to each semi-annual implementation support visit), of all data related to the Project indicators, including from relevant government agencies and other stakeholders. This performance information includes PDO-level and intermediate results indicators, PBCs, qualitative data on implementation progress of Components 1 and 2, and annual completion of the WHO's State Party Self-Assessment Annual Reporting Tool (SPAR) to track implementation progress on Component 3. Each directorate of the MoHSPP, other institutions engaged in project activities, and the TSG will perform their project-related functions in accordance with the provisions of the POM. Each institution will also appoint a focal point to ensure timely provision of project implementation updates.

52. **The health facility data for monitoring and evaluating project impacts on health service-readiness and healthcare quality – the quality-related PDO – will be collected through a series of nationwide FASTR surveys and SDI surveys at baseline (2023/24) and endline (2027).** The first two FASTR surveys and the baseline SDI survey will be funded and executed by the GFF and the Bank; the subsequent biannual FASTR surveys and the endline SDI survey will be financed by the Project under Component 4 and led by MoHSPP with support from the World Bank technical team. Both SDI surveys and the first two FASTR surveys will be executed by private survey firms. MoHSPP will support survey implementation by endorsing and facilitating field work; the Bank technical teams will carry out data analysis and ensure timely provision of survey findings to the Government. The private survey firm that will implement the endline SDI will be chosen by a joint MoHSPP–World Bank selection panel, and safeguards will be established for its independence in data collection and analysis. The TSG will also validate and provide administrative and qualitative data for M&E to the World Bank and other stakeholders in a timely manner. The administrative data include statistics from Tajikistan's DHIS on key inputs. The TSG will also provide up-to-date information from Tajikistan's National Health Accounts, and from the MoF on government

[45] Members will participate from the Ministry of Justice, Ministry of Finance, Ministry of Economic Development and Trade, Tax Committee, Anti-Monopoly Agency, Agency for State Financial Control and Combatting Corruption, Committee on Local Government, Ministry of Industry and New Technologies (Digital), State Committee on Investments and Management of State Property, and senior management level participants from Sughd Oblast Local Government and Dushanbe City Local Government.

health expenditures at the national and subnational levels by economic and functional classification. Furthermore, the TSG will gather and analyze timely and verified qualitative data on the implementation of all components.

C. Sustainability

53. **To ensure technical sustainability, the Project will invest in maintaining the project staff and civil servant capacity that was built under previous projects (HSIP, TEC-19 Project, ECDP)**.

54. **To ensure financial sustainability, the Project will:**

- only finance transitional recurrent costs – operational costs of the Health Services Purchasing Structure – that have a clear plan for being financed by the Government over time;
- redesign the PHC benefit package with focus on cost-effectiveness and existing and future fiscal envelope;
- design a domestic resource mobilization roadmap for the health sector;
- avert future healthcare costs by investing in PHC quality and accessibility which, prevents diseases and avoids complications that require costly specialist and hospital care;
- improve the efficiency of PHC spending by the deepening of strategic purchasing reforms under Component 2 and supporting the rightsizing of infrastructure and human resource needs via a new facility masterplan, the development of new models for service delivery, and the provision of data for evidence-based decision making.

55. **Institutional sustainability.** The Project is designed to implement priority actions in the NHS 2030 and the PIP and will support the overall direction of the health reforms in the country, including the Government's plans to implement a revised version of the Law on Health Insurance for which Component 2 will lay the groundwork. The Project does not create parallel structures; instead, it will work by making changes to existing government systems, such as PFM, and by investing in building the capacity of existing government institutions (MoF, MoHSPP) and new ones (Health Services Purchasing Structure). The placement of the TSG and other stakeholder institutions in the MoHSPP building will improve coordination between the staff hired by the Project and civil servants.

56. **Environmental sustainability.** The Project will support MoHSPP in improving standards for PHC facilities, considering the need for sustainability and climate resilience, using the Project as an example to set standards for the future. The plan to purchase solar panels and other alternative sustainable energy sources for PHC facilities will help mitigate the environmental impact of electricity used during service delivery.

IV. PROJECT APPRAISAL SUMMARY

A. Technical, Economic and Financial Analysis

Technical Appraisal

57. **The PDO will be achieved and sustained using a three-pronged approach that will improve the quality of PHC services, builds the national capacity to respond to health emergencies, and introduces structural reforms to the healthcare system.** First, Component 1 and Component 3 will invest in upgrading service delivery and public health systems to improve service-readiness, and thereby the quality and reach of PHC services, and emergency response capacity. Second, the Project will support structural reforms under Component 2, and fiscal changes – development of domestic resource mobilization roadmap for the health sector – that will allow for more cost-effective service delivery systems over time and, in the medium-term, for more resources to flow to the PHC and HEPR systems. This will, in turn, contribute to sustaining the investments under the Project and to expand efficiency-enhancing reforms beyond the pioneer regions.

58. **The Project is consistent with international best practice, by putting a focus on strengthening investments in PHC and HEPR systems, which are highly cost-effective investments to improve population health.** The Project will also focus on advancing digitalization, evidence-based decision-making, and rationalization of the service delivery network by bringing healthcare closer to patients and putting less emphasis on hospital care, which objectives are aligned with international best practice. While Component 2 objectives are ambitious, it has been designed taking into consideration the limited experience with the implementation of reforms in the health sector and the institutional capacity development needs that the Project must address to make the policy changes sustainable over time. The implementation arrangements and financing modalities – for example, performance-based mechanisms – have been successfully used in previous World Bank-financed projects, with satisfactory performance to date.

Economic Analysis

59. **A cost-benefit analysis (CBA) was carried out to assess the economic viability of the proposed intervention.** The CBA uses the discounted value method, assuming social discount rates of 4.5 and 9 percent to express future benefits and costs in present values.

60. **The Project is deemed cost-beneficial.** Benefits were derived from estimated reductions in mortality using the concept of Value of Statistical Life (VSL).[46] The comparison of the present values of benefits and costs yields a benefit-cost ratio (BCR) of 1.7–1.8 and a net present value (NPV) between US$30 million and US$37 million, indicating that the Project is cost-beneficial. Economic Analysis is available upon request.

61. **Global evidence shows that investments in PHC are highly cost-effective as they improve population health in an equitable manner, which yields large economic returns.** Investments in improved efficiency, equity, quality, and uptake of preventive and PHC services, such as those envisaged by this Project, are welfare-enhancing as they are associated with reductions in morbidity and mortality, which yield substantial economic gains.[47,48,49] For Tajikistan, better healthcare access and quality would avoid over 9,000 deaths annually.[50] Spending on effective PHC is allocatively efficient also because it prevents unnecessary and avoidable use of more expensive specialized and inpatient care; it also promotes equitable healthcare access. Better PHC has also the potential to be welfare-enhancing by reducing OOP spending for self-medication, which many Tajiks revert to. The substantive benefits of PHC investments have been shown to clearly outweigh their costs. For instance, a set of integrated interventions for maternal and child health alone is estimated to generate economic and health benefits in lower-middle-income countries valued at 11.3 times their costs.[51] To maximize the returns to investments in PHC, spending decisions need to be evidence-based. Therefore, efforts to improve data

[46] First, the share of the population reached by improved PHC was projected. Subsequently, the number of lives saved by improved PHC was computed assuming that improved PHC can save half of the lives lost due to poor quality of healthcare. Each life saved was then valued at a VSL estimate for Tajikistan of US$230,360 and discounted to its present monetary value. Cost estimates followed the planned disbursement schedule over the 2023-2028 period and were also discounted to present values using the above-stated social discount rates.

[47] Tandon, Ajay, Danielle Bloom, Lauren Oliveira Hashiguchi, Patrick Hoang-Vu Eozenou, Jewelwayne Cain, Aditi Nigam, and Somil Nagpal. 2021. Making the Case for Health: A Messaging Guide for Domestic Resource Mobilization. Joint Learning Network for Universal Health Coverage.

[48] Hanson, K., Nouria Brikci, Darius Erlangga, Abebe Alebachew, Manuela De Allegri, Dina Balabanova, Mark Blecher, Cheryl Cashin et al. 2022. "The Lancet Global Health Commission on financing primary health care: putting people at the centre."
The Lancet Global Health 10 (5): e715–e772..

[49] For instance, a recent study estimates that investments in improving PHC over the period from 2020 to 2030 would avert up to 64 million deaths in low- and middle-income countries. Source: Stenberg, K., Odd Hanssen, Melanie Bertram, Callum Brindley, Andreia Meshreky, Shannon Barkley et al. 2019. "Guideposts for investment in primary health care and projected resource needs in 67 low-income and middle-income countries: a modelling study." The Lancet Global Health 7: e1500–10.

[50] Kruk et al. 2018. "Mortality due to low-quality health systems in the universal health coverage era: a systematic analysis of amenable deaths in 137 countries."

[51] Stenberg, K., Henrik Axelson, Peter Sheehan, Ian Anderson, A. Metin Gülmezoglu, Marleen Temmerman. 2014. "Advancing social and economic development by investing in women's and children's health: a new global investment Framework." Lancet 383: 133–54.

availability through digitization and analytical capacity, as those proposed by the Project, are crucial. In summary, investments toward increased value-for-money in health expenditure are critical to ensuring progress toward UHC.[52]

Paris Agreement Alignment

62. **Assessment and reduction of adaptation risks**: The Climate and Disaster Risk Screening for this Project determined a low risk to Project investments. The main climate risks for the Project are flooding and extreme temperatures, which can disrupt healthcare services. The Project design addresses these risks by implementing climate adaptation measures, such as insulating buildings for extreme heat. Health workers will also be trained on climate hazard preparedness and managing climate-related health risks. Long-term strategies include incorporating climate modules in training materials for PHC and investing in the retention of PHC health workers in vulnerable areas. Mobile outreach programs will ensure continued service delivery in identified climate-vulnerable areas, while risk communication will enhance climate adaptation and resilience of the population. The development of a service delivery network masterplan that will map out climate-vulnerable areas will ensure that climate adaptation measures supported by this Project will target populations most affected by climate hazards.

63. **Assessment and reduction of mitigation risks:** The proposed Project is anticipated to have no activities which may result in greenhouse gas emissions or carbon lock-in. Building rehabilitation works will utilize energy-efficient building criteria to minimize potential emissions. The Project incorporates necessary measures to ensure that the procurement of equipment and materials meets energy-efficiency standards. Additionally, using an online learning platform to train PHC staff will reduce the need to travel, thereby reducing carbon emissions.

64. **On mitigation, the operation has a low risk of activities resulting in significant contributions to greenhouse gas emissions/carbon lock-in.** The operation adequately reduces the physical climate risks to the Project outcomes, and the Project's climate resilience and adaptation design considerations limit the exposure to a low level of residual risk. For Component 5 (CERC), a CERC Manual will include considerations for climate risks on both adaptation and mitigation to ensure it is Paris-aligned.

B. Fiduciary

(i) Financial Management

65. **The assessment confirmed that financial management (FM) arrangements at MoHSPP meet the minimum requirements of the World Bank's Policy and Directive on Investment Project Financing (IPF)**, subject to capacity building actions listed in the table below. The MoHSPP has gained good experience in World Bank fiduciary requirements by implementing the HSIP and the TEC-19. To strengthen the FM performance of MoHSPP, the following actions are recommended:

Table 4: Recommended Actions to Strengthening FM Performance

	Proposed Action	Timeline
1.	An FM chapter is developed and adopted by the MoHSPP as part of the POM to guide staff in daily FM operations, including details on PBC disbursement under the Project.	By Project effectiveness
2.	The existing accounting software used by the MoHSPP for the HSIP is configured to the design of the Millati Solim Project.	Within 30 days after Project effectiveness
3.	The existing FM staff (one FM Specialist and two Disbursement Specialists) who have supported the HSIP shall be contracted under the Millati Solim Project, since they have adequate experience of managing fiduciary functions satisfactorily.	Within 30 days after Project effectiveness

[52] Barış, Enis, Rachel Silverman, Huihui Wang, Feng Zhao, and Muhammad Ali Pate22 Walking the Talk: Reimagining Primary Health Care after COVID-

66. **Regarding the FM-related covenants to be included in the Disbursement and Financial Information Letter (DFIL), the following should be noted**: (i) ***Financial Reports***. The MoHSPP shall prepare and furnish to IDA not later than forty-five (45) days after the end of each calendar quarter, interim unaudited financial reports (IFRs) for the Project covering the quarter, in form and substance satisfactory to the Association. (ii) ***Audits***. Each audit of the Project Financial Statements shall cover the period of one fiscal year of the Recipient, commencing with the fiscal year in which the first withdrawal was made. The audited Financial Statements for each such period shall be furnished to the Association not later than six (6) months after the end of such period and made publicly available in a timely fashion and in a manner acceptable to the Association.

67. **Disbursements from the financing grant account will be made in accordance with the Disbursement Guidelines for IPF** (dated May 2017) and will use the following disbursement methods: direct payment, special commitments, reimbursement, and advances to a Designated Account (DA). Withdrawal applications shall be accompanied by appropriate supporting documentation - summary sheets with records and/or statements of expenditures included in the DFILs and in accordance with procedures described in the Disbursement Guidelines and the Guidance on IPF with PBCs. To facilitate advances, MoHSPP will open Designated Accounts (DAs) for each source of financing: two DAs will be opened for IDA financing, one DA for HEPR TF financing, and two DAs for GFF TF in a financial institution acceptable to the Association. Under the PBC DAs, the incurred expenditures will be documented after the respective PBT is achieved. If the expenditures are paid from the DA but the PBT is not achieved, then the Recipient must refund that amount to the Bank, as it becomes an ineligible expenditure. The deadline for the refund will be the disbursement deadline date.

68. In case the PBT are not achieved in time, and the Recipient fails to document the advance provided, even though the expenditures were incurred, the PBC funds will be unavailable to the Project until the PBT is achieved. A mechanism for PBC disbursements will be described in the POM. The detailed disbursement arrangements for the Project are specified in the DFIL.

(ii) Procurement

69. **Procurement processing under the Project will be conducted in accordance with the procedures specified in the World Bank's Procurement Regulations for IPF[53] Borrowers/Recipients – Goods, Works, Non-Consulting and Consulting Services**, dated November 2020 (Procurement Regulations). The Project will also be subject to the World Bank's Anti-Corruption Guidelines, dated July 1, 2016. The procurement and contract management processes will be tracked through the Systematic Tracking of Exchanges in Procurement (STEP) system. As required by the Procurement Regulations, a Project Procurement Strategy for Development (PPSD) was prepared, providing a justification for the procurement and selection methods to be followed by the Borrower during Project implementation in the procurement of goods, works, non-consulting and consulting services financed by the World Bank, and the agreed procurement activities, procurement methods and other details are indicated in the procurement plan. A procurement section detailing the procurement procedures to be followed during Project implementation will be included in the POM.

70. **The procurement assessment identified risks and mitigation measures,** both of which are presented in Annex 6. Based on the findings, MoHSPP gained experience in the use of the World Bank procurement regulations under the HSIP and TEC-19 Project. The MoHSPP should ensure that technical expertise is in place to timely develop ToRs and technical specifications, cost estimates, and technical input in procurement documents and during the selection process as well as review and approve the deliverables/outputs at contract management stage to mitigate delays during the procurement cycle. Other risks and agreed actions are indicated in the table below:

[53] Procurement in Investment Project Financing.

Table 5: Recommended Actions to Strengthen Procurement Performance

No.	Proposed Action	Timeline
1	Procurement section will be included in the POM to guide staff in daily procurement operations under the Project.	By Project effectiveness
2	Two Procurement Specialists with ToR acceptable to the Bank will be hired. It was agreed that the procurement staff[54] who have supported the HSIP can be hired under the Millati Solim Project.	Within 30 days after Project effectiveness
3	Timely planning and monitoring of procurement progress through at least monthly meeting and use of eGP system for all contracts subject to National approach.	Throughout Project life
4	Regular monitoring of and reporting on civil works by the Capital Construction Directorate of the MoHSPP and TSG engineers.	Throughout Project life
5	Involvement of the Capital Construction Directorate and local authorities in the identification of facilities.	Prior to start of any activity related to facilities

71. The major planned procurements include:

a) **Goods:** (i) basic medical and laboratory equipment and medical and office furniture for PHC facilities; (ii) solar panels and other alternative energy sources for PHC facilities; and (iii) computers/tablets/smartphones and internet access/local area networks (LAN) for rural PHC facilities.
b) **Civil works:** construction of new PHC facilities, rehabilitation of existing PHC facilities and the Republican Clinical Training Center, including its six regional branches, and rehabilitation of selected SES regional offices, warehouses and laboratories.
c) **Consulting Services:** (i) costing of the primary healthcare benefit package; (ii) development of a service delivery network masterplan/optimization plan to optimize services delivery; (iii) support for the introduction of a national accreditation program for PHC providers; and (iv) creation and capacity building of a Health Services Purchasing Structure.

C. Legal Operational Policies

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

D. Environmental and Social

Environmental Aspects

72. **The Project's environmental risk is Moderate.** Activities under Component 1.2 will mainly finance rehabilitation and repair, equipping, and modernization of existing PHC facilities, and construction of new priority PHC facilities and SES regional offices, warehouses, and laboratories in selected districts. Given the complexity of the country's terrain, the requirement for health facilities and construction/modernization may vary significantly. However, the infrastructure modernization operations may include procurement of equipment, building warehouses, installation or rehabilitation of incinerators, and expansion of existing health facilities. Potential environmental impacts and risks include (i) an increase

[54] Since they have adequate experience of managing fiduciary functions satisfactorily.

in healthcare waste due to poor waste management in terms of waste color coding, segregation, collection, decontamination, transportation, and disposal as well as occupational health and safety (OHS) issues; (ii) health care workers occupational health and safety; (iii) community health and safety related to operation of health care facilities; and (iv) air pollution. These will be mitigated through: (i) capacity-building activities, aimed at strengthening health facilities to comply with the World Bank Environmental and Social Framework (ESF) requirements, particularly, Environmental and Social Standards (ESS) 2 and 3: Resource Efficiency and Pollution Prevention and Management; (ii) implementation of environmental instruments prepared for the Project; and (iii) compliance with international best practice during construction/rehabilitation and operational stages. Moreover, an Environmental and Social Management Framework (ESMF) has been prepared during the Project appraisal stage. The ESMF establishes procedures for screening mitigation measures, and implementation arrangements. The environmental and social (E&S) impacts will be managed during Project implementation in accordance with the ESMF and Infection Control and Waste Management Plans (ICWMP) to be prepared in accordance with international good practice and the WHO standards. Environmental risks associated with the implementation of civil works will be mitigated by the application of the World Bank Environmental Health and Safety Guidelines (EHSGs) and Good International Industrial Practices (GIIPs) for civil works. These and all other potential environmental risks are reversible and are easily managed by the implementation of proper Environmental and Social tools and plans. The Project Environmental and Social Commitment Plan (ESCP) and subsequent Environmental and Social Management Plans (ESMPs) and ICWMPs will have sufficient guidance and provisions to mitigate any potential environmental and social risks and impacts of the Project activities.

73. **It is difficult to describe potential risks and mitigation measures associated with emergency response and likely vulnerable locations and/or groups in the ESMF.** In the event of an emergency, the Project ESMF shall be updated by adding a special chapter outlining the potential activity screening process, institutional arrangements for environmental and social due diligence, monitoring, and necessary capacity-building measures. Any potential E&S high-risk activities will not be financed by Component 5, nor by any other components of the Project.

Climate Change

74. **The Project was screened for short and long-term climate change and disaster risks. The risk of climate hazards on Project location and beneficiaries is rated as high, but the risk to Project outcomes is considered low due to the Project's climate resilience strategies.** Tajikistan's mean annual temperature between 1990 and 2020 was 3.74℃, and it is expected to rise to 5.8°C[55] by the 2090s, compared to the global average increase of 3.7°C. Annual precipitation during 1990-2020 was 688.04mm. Extreme rainfall is projected to increase with temperature. The country faces multiple hazards, including earthquakes, floods, droughts, avalanches, landslides, and mudslides. Floods are the most frequent hazard, while 36 percent of the country is at risk of landslides. Landslides have affected 13,728 people in 2006, and floods affected 12,750 people in 2016. The Khatlon region was particularly impacted by floods and landslides in May 2021.[56] Earthquakes account for 15 percent of climate hazards between 1980-2020, affecting 22,430 individuals in 2006/7. Tajikistan ranks[s] 8th globally in terms of drought risk, with around 3 million people affected in 2000. The probability of experiencing droughts is projected to increase from 3 percent to 25 percent by 2050.

75. **Climate change and hazards have negative impacts on human health in Tajikistan**. Climate change has led to the worst nutrition outcomes in Tajikistan compared to other countries in Central Asia.[57] Crop yields for maize, wheat, fruits, and barley have decreased and is expected to decrease by approximately 20 percent, 15 percent, 11 percent, and 10

[55] Estimates under the highest emissions pathway (RCP8.5).
[56] https://reliefweb.int/disaster/fl-2021-000055-tjk.
[57] World Food Programme. 2017. *Climate Risks and Food Security in Tajikistan: A Review of Evidence and Priorities for Adaptation Strategies*. https://docs.wfp.org/api/documents/WFP-0000015482/download/.

percent between the period 2015 to 2050.[58] Without climate adaptation measures, moderate stunting of children under 5 years old in Central Asia is projected to reach 1.2 percent in 2030 and 2 percent by 2050.[59, 60] Diarrhea, which is a major health burden in Tajikistan, is exacerbated by climate hazards like floods that affect water quality. Climate change is estimated to increase the number of diarrhea-related deaths in Central Asia by 11 percent by 2030. Typhoid cases in Tajikistan are also linked to climate change, with 70 percent occurring during warmer periods.[61] Hotter years have seen typhoid death rates approximately 2.5 times higher than average. The country's lack of emergency management capacity has made it more vulnerable to climate hazards, contributing to these poor health outcomes.

76. **The Republic of Tajikistan has shown commitment to address climate change with the climate-related activities under the proposed Project aligning with the country's climate priorities.** Tajikistan ratified the Paris Climate Agreement in 2016 and updated its National Determined Contribution (NDC) in 2021. The country has focused on building institutional capacity and awareness for climate mitigation, implementing policies like the National Development Strategy up to 2030.[62] This strategy highlights the country's high risk to climate hazards and promotes activities for climate adaptation measures and mainstreaming climate change issues. Furthermore, Tajikistan has prepared three National Communications on climate change and has approved a National Action Plan on climate risk mitigation. The biennial report (2018) provides actions to mitigate climate change,[63] including building capacity of communities on climate resilience and conducting climate impact assessments. The National Strategy for adaptation to climate change for the period until 2030 highlights the health sector as particularly vulnerable to the impacts of climate change.[64] Tajikistan has also developed the National Strategy for the Activation of the Role of Women[65] to address gender-specific vulnerabilities to climate change and improve climate change data with gender-sensitive indicators. Annex 1 details the measures through which the Project addresses these vulnerabilities and enhance climate resilience and adaptation, while mitigating greenhouse gas emissions.

Social Aspects

77. **The Project will have positive social impacts**, as it will contribute to (i) improved quality of PHC services in selected districts/regions, and (ii) strengthening national capacity to respond to health emergencies. Social risks could emanate from the following planned investments: (i) service delivery capacity (human resources, infrastructure, and equipment) at the PHC level in selected districts and at the national level, and (ii) national capacity and physical infrastructure enhancement to improve response to various emergencies. The following social risks and impacts have been identified: (i) social exclusion; (ii) resettlement impacts; (iii) risks related to institutional capacity; and (iv) labor-related risks. One of the key social challenges for the Project will be to ensure social inclusion due to differentiation in geographical coverage, scale of investments, Information and Communication Technology absorption capacity, administrative expediency, and the economy in outreach activities. The exclusion risk will be addressed mainly through a well-crafted Stakeholder Engagement Plan (SEP) supplemented with an effective Information, Education and Communication campaign. The Project will also implement an Annual National Patient Survey under Component 1 to measure satisfaction of healthcare service users at the PHC level. This will facilitate better understanding of the demand for PHC services and how satisfaction rates

[58] World Food Programme. 2017. *Climate Risks and Food Security in Tajikistan*.
[59] WHO. 2014. *Quantitative risk assessment of the effects of climate change on selected causes of death, 2030s and 2050s*. https://apps.who.int/iris/bitstream/handle/10665/134014/9789241507691_eng.pdf.
[60] WHO. 2014. *Quantitative risk assessment of the effects of climate change on selected causes of death, 2030s and 2050s*.
[61] Tajikistan. 2019. *Biennial update report*. https://unfccc.int/documents/198521.
[62] UN ESCAP. 2021. "Implementing the Paris Agreement in Central Asia." https://www.unescap.org/sites/default/d8files/knowledge-products/Paris%20Agreement%20Implementation%20in%20Central%20Asia.pdf.
[63] Tajikistan. 2019. *Biennial update report*.
[64] https://cis-legislation.com/document.fwx?rgn=119703.
[65] https://www.climate-laws.org/legislation_and_policies?from_geography_page=Tajikistan&geography%5B%5D=177&type%5B%5D=executive.

are changing over time as Project investments strengthen PHC services in target areas. The exclusion list of activities is provided in ESCP in box 1.5.

78. **The Project involves civil construction, in terms of building some new and repairing, extending and/or rehabilitating other PHC facilities.** Rehabilitation works will lead to temporary impacts related to limited access to healthcare facilities and services. The new construction will invariably require land acquisition. While the Government is expected to make land available, due diligence is required to ensure that there is no resultant physical and/or economic displacement. Resettlement risks will be addressed through implementation of a Resettlement Framework. Another challenge will be sensitizing the implementing agency and other relevant stakeholders to adopt and adhere to the ESF requirements, as some regional and local stakeholders will be new to those requirements. There are also risks related to institutional capacity, transparency of decisions made under Subcomponent 1.2. These risks shall be mitigated through implementation of ESF capacity building activities, social accountability mechanisms and tools (independent monitoring of project outcomes) to improve Project outcomes. Labor-related risks will be mitigated through implementation of Labor Management Procedures.

79. **The Project is assigned a moderate risk rating for Sexual Exploitation and Abuse/Sexual Harassment (SEA/SH).** The Project will support the integration of GBV services at the PHC level. It will also finance the implementation of selected activities and development of national policy, which include development of expertise and training to recognize, prevent, and respond to GBV. Within three months after the Effective Date, the Project will prepare, adopt, and implement a SEA/SH Action Plan to assess and manage the risks of GBV and SEA/SH at the Project level, and implement the Action Plan throughout Project implementation. Adequate SEA/SH mitigation measures will also be included in the site-specific ESMPs to be prepared and implemented by contractors. Civil works will be implemented in the vicinity of health facilities or fenced territories. There might be selection of some remote, hard-to-supervise mountainous districts. The Project's grievance mechanisms will have appropriate approaches for dealing with SEA/SH complaints, including confidential and sensitive referral mechanism.

80. **Gender inequality is a major challenge in the country with implications for women's access to healthcare.** There is a high and increasing prevalence of GBV. The Government shows increased commitment to fight GBV. Recently the Parliament discussed amending the Law on the Prevention of Domestic Violence to address previous weaknesses and align it with international good practice.[66] To prepare for the implementation of the amended Law on the Prevention of Domestic Violence, Subcomponent 1.1 will support the integration of GBV services in the health sector with a particular focus on the primary care level.

81. **Citizen engagement (CE).** The Project has a robust CE approach, which includes, under Component 1, financing of an Annual National Patient Survey to measure people's view and satisfaction with healthcare services at the PHC level. The survey will be nationally representative and include socially vulnerable groups, such as women, elderly, and people with disability. It is critical for MoHSPP to collect this data to stay tuned to the needs and demands of the population and receive feedback from citizens, and particularly vulnerable groups, on a regular basis to inform policy decisions in the health sector. The survey methodology will include the outreach actions specifically tailored to engage socially vulnerable groups (such as women, elderly, and people with disability). Other ways the Project will contribute to CE include:

[66] High-priority amendments include provision of free services for victims of domestic violence, including adequate support to affected or dependent children, extending protective orders, minimum coverage of support services, strengthening of referral mechanisms and the discussion of the role of additional government institution in preventing domestic violence. Source: Comments of the World Bank Group and United Nations Populations Fund on the Law of the Republic of Tajikistan on the Prevention of Domestic Violence (*Abhori Majlisi Oli* of the Republic of Tajikistan, 2013, No. 3, v. 197).

- SMS-based outreach through Mobile Engage, including to socially vulnerable groups, will be financed to raise awareness of MoHSPP's GRM system and increase its use.
- Independent monitoring of project outcomes will be carried out. Annual roundtables with the Project beneficiaries will be conducted to disseminate/ discuss results of the national surveys and the GRM, and actions will be taken based on citizens´ suggestions. This, in combination with facility surveys financed under Component 4, will be used to improve accountability, and increase transparency of Project implementation to the citizens of Tajikistan.
- The existing MoHSPP GRM will be used, publicized, maintained, and operated in a transparent manner that is culturally appropriate and readily accessible to all Project-affected parties. Using the mechanism will be at no cost to citizens, without retribution, and will include concerns and grievances filed anonymously, in a manner consistent with ESS10. The TSG will develop the guidelines for CE mechanisms in the POM to ensure that CE activities are immediately launched under the Project. To ensure that there is a feedback loop between citizens' suggestions and policy decisions/actions, the results of the different data sources listed above will be discussed by senior management of the MoHSPP on a biannual basis. The results framework includes a CE indicator.[67]

V. GRIEVANCE REDRESS SERVICES

82. ***Grievance Redress.*** Communities and individuals who believe that they are adversely affected by a Project supported by the World Bank may submit complaints to existing Project-level grievance mechanisms or the Bank'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 Bank's independent Accountability Mechanism (AM). The AM houses the Inspection Panel, which determines whether harm occurred, or could occur, as a result of Bank non-compliance with its policies and procedures, and the Dispute Resolution Service, which provides communities and borrowers with the opportunity to address complaints through dispute resolution. Complaints may be submitted to the AM at any time after concerns have been brought directly to the attention of Bank Management and after Management has been given an opportunity to respond. For information on how to submit complaints to the Bank's Grievance Redress Service (GRS), visit http://www.worldbank.org/GRS. For information on how to submit complaints to the Bank's Accountability Mechanism, visit https://accountability.worldbank.org.

VI. KEY RISKS

83. **The overall risk to achieving the PDO is Substantial and reflects a combination of the technical design risk and the uncertain economic and geopolitical outlook.** The following risks are rated Substantial: Macroeconomic, Institutional Capacity for Implementation and Sustainability, Fiduciary (Procurement is substantial while Financial Management is moderate), Stakeholder, and Other (related to natural disasters and climate change). Political and Governance as well as Technical Design risks are rated as High. The category of risks (rated substantial and high) is further described in Annex 6, including residual risks and proposed mitigation measures. Risk assessments and mitigation strategies build on the ongoing HSIP and preceding projects and incorporate lessons learned.

[67] Support will be provided to the TSG to develop guidelines for CE mechanisms in the Project Operations Manual before effectiveness and to reflect all CE activities in the Stakeholder Engagement Plan.

VII. RESULTS FRAMEWORK AND MONITORING

PDO Indicators by PDO Outcomes

Baseline	Period 1	Period 2	Period 3	Period 4	Period 5	Period 6	Closing Period
To improve the quality of primary healthcare services in selected districts							
Number of people residing in catchment areas of service-ready district and city health centers (Number)							
Jan/2023	Dec/2023	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028	Dec/2028
0.00	0.00	0.00	993,858.00	1,695,404.00	1,812,329.00	1,812,329.00	1,812,329.00
Number of people residing in catchment areas of service-ready rural health centers (Number)							
Jan/2023	Dec/2023	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028	Dec/2028
0.00	0.00	0.00	141,961.00	259,758.00	302,044.00	323,188.00	323,188.00
Number of outpatient contacts with service-ready PHC facilities (cumulative) (Number)							
Jan/2023	Dec/2023	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028	Dec/2028
0.00	0.00	0.00	3,692,637.00	10,022,515.00	17,119,889.00	24,405,395.00	24,405,395.00
To improve the efficiency of primary healthcare services in selected districts							
Percent of district and city health centers in pioneer regions contracted (Percentage)							
Feb/2023	Dec/2023	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028	Dec/2028
0.00	0.00	0.00	0.00	0.00	0.00	100.00	100.00
To strengthen the national capacity to respond to public health emergencies							
Percent of health alerts generated by routine or immediate reporting that receive initial investigation within 72 hours (Percentage)							
Jan/2023	Dec/2023	Dec/2024	Dec/2025	Dec/2026			Dec/2026
0.00	0.00	20.00	50.00	75.00			75.00

Intermediate Indicators by Components

Baseline	Period 1	Period 2	Period 3	Period 4	Period 5	Period 6	Closing Period
Component 1: Quality Improvements of Primary Care through Primary Healthcare Strengthening							
Number of doctors having completed 6-month family medicine training in selected districts (cumulative) (Number)							
Jan/2023	Dec/2023	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028	Dec/2028
0.00	0.00	60.00	140.00	220.00	300.00	350.00	350.00
➢Number of nurses having completed 6-month family medicine training in selected districts (cumulative) (Number)							
0.00	0.00	120.00	240.00	400.00	550.00	700.00	700.00

➢Number of female doctors having completed 6-month family medicine training (cumulative) (Number)							
0.00	0.00	6.00	14.00	22.00	30.00	35.00	35.00
➢Number of female nurses having completed 6-month family medicine training (cumulative) (Number)							
0.00	0.00	90.00	180.00	300.00	413.00	525.00	525.00
People who have received essential health, nutrition, and population (HNP) services (Number) [CRI]							
Jan/2023	Dec/2023	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028	Dec/2028
0.00	0	0	4842	12333	21669	31407	31407
➢Number of children immunized (Number) [CRI]							
Jan/2023	Dec/2023	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028	Dec/2028
0.00	0.00	0.00	4842.00	12333.00	21669.00	31407.00	31407.00
Number of healthcare workers having completed training on Gender-Based-Violence (GBV) (cumulative) (Number)							
Jan/2023	Jun/2023	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028	Dec/2028
0.00	0.00	800.00	1,600.00	2,200.00	2,900.00	3,600.00	3,600.00
Number of PHC facilities providing GBV response services (Number)							
Jan/2023	Jun/2024	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028	Dec/2028
0.00	0.00	0.00	40.00	80.00	120.00	180.00	180.00
Percentage of respondents of national citizen survey that report satisfaction with received PHC services (Percentage)							
Jan/2023	Dec/2023	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028	Dec/2028
Baseline will be established in the first year of the implementation	0.00	20.00	25.00	30.00	35.00	40.00	40.00
Number of district and city health centers with improved service delivery conditions (constructed and equipped) (Number)							
Jan/2023	Dec/2023	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028	Dec/2028
0.00	0.00	7.00	9.00	9.00	9.00	9.00	9.00
➢Number of rural health centers with improved service delivery conditions (constructed and equipped) (cumulative) (Number)							
0.00	0.00	10.00	20.00	26.00	28.00	28.00	28.00
➢Number of district and city health centers with improved service delivery conditions (rehabilitated and equipped) cumulative) (Number)							
0.00	0.00	3.00	3.00	3.00	3.00	3.00	3.00
➢Number of rural health centers with improved service delivery conditions (rehabilitated and equipped) (cumulative) (Number)							
0.00	0.00	11.00	20.00	28.00	33.00	33.00	33.00
Component 2: Efficiency-enhancing Reforms in the PHC Network							
Policy and institutional reforms for introducing strategic purchasing adopted (Text) [PBC]							
Jan/2023	Dec/2025	Dec/2026	Dec/2026	Dec/2027	Dec/2027		Aug/2028

n/a	National health service delivery network optimization plan has been developed and approved by Recipient	Single state-guaranteed benefit package for PHC developed, costed, and approved by Recipient	Staffing norms for PHCs revised and approved by Recipient	Regulatory framework to increase the PHC providers' autonomy developed and approved by Recipient	(i) The Health Services Purchasing Structure has been established by Recipient; (ii) a multi-year human resources plan has been developed based on international good practices and adopted by the Recipient; and (iii) the Health Services Purchasing Structure has been staffed according to multi-year human resources plan adopted in 2027		The Health Services Purchasing Structure has been staffed according to multi-year human resources plan adopted in 2028
Electronic Patient Registry (EPR) and Electronic Medical Records (EMR) are functional. (Text) PBC							
Feb/2023	Dec/2024	Dec/2025	Dec/2026				Dec/2027
n/a	0.00	0.00	Electronic Patient Registry (EPR) is functional, integrated with the civil registry				Electronic Medical Records (EMR) are functional
Component 3: Health Emergency Preparedness and Response							
Percent of district SES laboratories that report data on priority diseases (Percentage)							
Jan/2023	Dec/2023	Dec/2024	Dec/2025	Dec/2026			Dec/2026
0.00	0.00	10.00	30.00	60.00			60.00
Number of simulation exercises conducted to improve functionality of HEPR coordinating mechanisms (cumulative) (Number)							
Jan/2023	Dec/2023	Dec/2024	Dec/2025	Dec/2026			Dec/2026
0.00	0.00	2.00	4.00	4.00			4.00
Number of public health officials and health professionals trained in updated surveillance and emergency management (cumulative) (Number)							
Jan/2023	Dec/2023	Dec/2024	Dec/2025	Dec/2026			Dec/2026

0.00	0.00	200.00	350.00	500.00			500.00
Component 4: Project Management, Coordination, and Results Monitoring							
Number of FASTR surveys completed, including consultation meetings between World Bank and Government (Cumulative) (Number)							
Jan/2023	Dec/2023	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028	Dec/2028
0.00	1.00	3.00	5.00	7.00	9.00	10.00	10.00
Health facilities constructed, renovated, and/or equipped (Cumulative) (Number)							
Jan/2023	Dec/2023	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028	Dec/2028
0.00	0.00	0.00	64.00	110.00	175.00	248.00	248.00
Number of health sector staff trained (Cumulative) (Number)							
Feb/2023	Dec/2023	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028	Dec/2028
0.00	0.00	3,997.00	4,256.00	5,612.00	6,724.00	4,840.00	10,468.00
Component 5: Contingent Emergency Response							

Performance-based Conditions (PBC)

Period	Period Definition	Timeline
Period 1	By December 31, 2025	2025
Period 2	By December 31, 2026	2026
Period 3	By December 31, 2026	2026
Period 4	By December 31, 2027	2027
Period 5	By December 31, 2027	2027
Period 6	By August 31, 2028	2028

Baseline	Period 1	Period 2	Period 3	Period 4	Period 5	Period 6
1 : Policy and institutional reforms for introducing strategic purchasing adopted (Text)						
n/a	National health service delivery network optimization plan has been developed and approved by Recipient's governmental decree	Single state-guaranteed benefit package for PHC developed, costed, and approved by Recipient's governmental decree	Staffing norms for PHCs revised and approved by Recipient's governmental decree	Regulatory framework to increase the PHC providers' autonomy developed and approved by Recipient's governmental decree	(i) The Health Services Purchasing Structure has been established by Recipient; (ii) a multi-year human resources plan has been developed based on international good practices and adopted by the Recipient; and	The Health Services Purchasing Structure has been staffed according to multi-year human resources plan adopted in 2028

					(iii) the Health Services Purchasing Structure has been staffed according to multi-year human resources plan adopted in 2027	
0.00	900,000.00	500,000.00	1,300,000.00	1,300,000.00	300,000.00	100,000.00
PBC allocation		4,400,000.00		As a % of Total PBC allocation		0.0%
2 : Electronic Patient Registry (EPR) and Electronic Medical Records (EMR) are functional. (Text)						
n/a	0.00	Electronic Patient Registry (EPR) is functional, integrated with the civil registry	0.00	Electronic Medical Records (EMR) are functional	0.00	0.00
0.00	0.00	900,000.00	0.00	900,000.00	0.00	0.00
PBC allocation		1,800,000.00		As a % of Total PBC allocation		0.0%

Monitoring & Evaluation Plan: PDO Indicators by PDO Outcomes

To improve the quality of primary healthcare services	
Number of people residing in catchment areas of service-ready district and city health centers (Number)	
Description	Population residing in catchment area of district and city health centers brought to service-readiness by Project investments. Service-readiness is achieved if a facility has the basic infrastructure/ amenities, essential equipment, medicines, and the healthcare workers with the required skills to provide basic PHC interventions relating to reproductive, maternal and child health, and infectious and non-communicable diseases. A service-readiness index specific to district and city health centers will grade facilities on a 0-100 scale, and a service-readiness score threshold to distinguish service-ready from non-service-ready facilities will be developed.
Frequency	Annual
Data source	TSG (catchment area population) and SDI surveys (service-readiness baseline and endline) as well as FASTR for intermediate monitoring
Methodology for Data Collection	Project reporting and facility surveys
Responsibility for Data Collection	TSG and World Bank
Number of people residing in catchment areas of service-ready rural health centers (Number)	
Description	Population residing in catchment area of rural health centers brought to service-readiness by Project investments. Service-readiness is achieved if a facility has the basic infrastructure/ amenities, essential equipment, medicines, and the healthcare workers with the required skills to provide basic PHC interventions relating to reproductive, maternal and child health, and infectious and non-communicable diseases. A service-readiness index specific to rural health centers will grade facilities on a 0-100 scale, and a service-readiness score threshold to distinguish service-ready from non-service-ready facilities will be developed.
Frequency	Annual
Data source	TSG (catchment area population) and SDI surveys (service-readiness baseline and endline) as well as FASTR for intermediate monitoring
Methodology for Data Collection	Project reporting and facility surveys
Responsibility for Data Collection	TSG and World Bank
Number of outpatient contacts with service-ready PHC facilities (cumulative) (Number)	

Description	Cumulative number of outpatient contacts with facilities that received Project investments and were assessed as service-ready following the above-mentioned methodology. Includes facility visits and home visits by family doctors and nurses.
Frequency	Annual
Data source	TSG (outpatient contacts) and SDI surveys (service-readiness baseline and endline) as well as FASTR for intermediate monitoring
Methodology for Data Collection	Project reporting and facility surveys
Responsibility for Data Collection	TSG and World Bank
To improve the efficiency of primary healthcare services in selected districts	
Percent of district and city health centers in pioneer regions contracted (Percentage)	
Description	Numerator: Number of district and city health centers contracted by Health Services Purchasing Structure and number of rural health centers subcontracted by district and city health centers. Denominator: Total number of district, city, and rural health centers in pioneer regions.
Frequency	Annual
Data source	TSG
Methodology for Data Collection	Project reporting
Responsibility for Data Collection	TSG
To strengthen the national capacity to respond to public health emergencies	
Percent of health alerts generated by routine or immediate reporting that receive initial investigation within 72 hours (Percentage)	
Description	Denominator: Number of health alerts during the Project period. Numerator: Number of health alerts investigated by relevant delegated national or subnational health authorities within 72 hours.
Frequency	Annual
Data source	MoHSPP
Methodology for Data Collection	MoHSPP reporting
Responsibility for Data Collection	MoHSPP

Monitoring & Evaluation Plan: Intermediate Results Indicators by Components

Component 1 - Quality Improvements of Primary Care through Primary Healthcare Strengthening	
Number of doctors having completed 6-month family medicine training in selected districts (cumulative) (Number)	
Description	Cumulative number of doctors completing Project-funded family medicine training
Frequency	Annual
Data source	TSG
Methodology for Data Collection	Project reporting
Responsibility for Data Collection	TSG
Number of nurses having completed 6-month family medicine training in selected districts. (cumulative) (Number)	
Description	Cumulative number of nurses completing Project-funded family medicine training
Frequency	Annual
Data source	TSG
Methodology for Data Collection	Project reporting
Responsibility for Data Collection	TSG
Number of female doctors having completed 6-month family medicine training (cumulative) (Number)	
Description	Cumulative number of female doctors completing Project-funded family medicine training
Frequency	Annual
Data source	TSG
Methodology for Data Collection	Project reporting
Responsibility for Data Collection	TSG
Number of female nurses having completed 6-month family medicine training (cumulative) (Number)	
Description	Cumulative number of female nurses completing Project-funded family medicine training
Frequency	Annual
Data source	TSG
Methodology for Data Collection	Project reporting
Responsibility for Data	TSG

Collection	
People who have received essential health, nutrition, and population (HNP) services (Number) [CRI]	
Description	
Frequency	Annual
Data source	TSG
Methodology for Data Collection	Project reporting
Responsibility for Data Collection	TSG
People who have received essential health, nutrition, and population (HNP) services - Female (RMS requirement) (Number) [CRI]	
Description	
Frequency	Annual
Data source	TSG
Methodology for Data Collection	Project reporting
Responsibility for Data Collection	TSG
Number of children immunized (Number) [CRI]	
Description	
Frequency	Annual
Data source	TSG
Methodology for Data Collection	Project reporting
Responsibility for Data Collection	TSG
Number of healthcare workers having completed training on Gender-Based-Violence (GBV) (cumulative) (Number)	
Description	Cumulative number of healthcare workers completing Project-funded training on Gender-Based-Violence (GBV)
Frequency	Annual
Data source	TSG
Methodology for Data Collection	Project reporting
Responsibility for Data Collection	TSG

Number of PHC facilities providing GBV response services (Number)	
Description	Cumulative number of PHC facilities where Project-trained healthcare workers provide GBV response services
Frequency	Annual
Data source	TSG
Methodology for Data Collection	Project reporting
Responsibility for Data Collection	TSG
Percentage of respondents of national citizen survey that report satisfaction with received PHC services (Percentage)	
Description	The baseline would be established during first year of implementation as it requires a survey.
Frequency	Annual
Data source	TSG
Methodology for Data Collection	Project reporting
Responsibility for Data Collection	TSG
Number of district and city health centers with improved service delivery conditions (constructed and equipped) (cumulative) (Number)	
Description	Cumulative number of district and city health centers constructed and equipped by the Project
Frequency	Annual
Data source	TSG
Methodology for Data Collection	Project reporting
Responsibility for Data Collection	TSG
Number of rural health centers with improved service delivery conditions (constructed and equipped) (cumulative) (Number)	
Description	Cumulative number of rural health centers constructed and equipped by the Project
Frequency	Annual
Data source	TSG
Methodology for Data Collection	Project reporting
Responsibility for Data Collection	TSG

Number of district and city health centers with improved service delivery conditions (rehabilitated and equipped) (cumulative) (Number)	
Description	Cumulative number of district and city health centers rehabilitated and equipped by the Project
Frequency	Annual
Data source	TSG
Methodology for Data Collection	Project reporting
Responsibility for Data Collection	TSG
Number of rural health centers with improved service delivery conditions (rehabilitated and equipped) (cumulative) (Number)	
Description	Cumulative number of rural health centers rehabilitated and equipped by Project
Frequency	Annual
Data source	TSG
Methodology for Data Collection	Project reporting
Responsibility for Data Collection	TSG
Component 2 - Efficiency-enhancing Reforms in the PHC Network	
Policy and institutional reforms for introducing strategic purchasing adopted (Text) PBC	
Description	The foundations for introducing strategic purchasing of healthcare services will be built. PBT (1.1) (by December 31, 2025): National health service delivery network optimization plan has been developed and approved. PBT (1.2) (by December 31, 2026): Single state guaranteed benefit package (SGBP) for PHC developed, costed, and approved. PBT (1.3) (by December 31, 2026): Staffing norms for PHCs revised and approved. PBT (1.4) (by December 31, 2027): Regulatory framework to increase the PHC providers' autonomy developed and approved. PBT (1.5) (PBT 1.5(a) by December 31, 2027 and PBT 1.5(b) by August 31, 2028): Health Services Purchasing Structure established and staffed.
Frequency	Annual
Data source	IVA
Methodology for Data Collection	Adoption of Government decree and/or MoHSPP orders
Responsibility for Data Collection	MoHSPP
Electronic Patient Registry (EPR) and Electronic Medical Records (EMR) are functional. (Text) PBC	
Description	The foundations for digitalizing the information in the PHC network will be built. PBT (2.1) (by December

	31, 2026) Electronic Patient Registry (EPR) is functional and integrated with the civil registry; PBT (2.2) (by December 31, 2027) Electronic Medical Records (EMRs) are functional.
Frequency	Annual
Data source	MoHSPP
Methodology for Data Collection	MoHSPP and IVA
Responsibility for Data Collection	MoHSPP
Component 3 - Health Emergency Preparedness and Response	
Number of simulation exercises conducted to improve functionality of HEPR coordinating mechanisms (cumulative) (Number)	
Description	Cumulative number of simulation exercises of various scale and types.
Frequency	Annual
Data source	TSG
Methodology for Data Collection	Project reporting
Responsibility for Data Collection	TSG
Percent of district SES laboratories that report data on priority diseases (Percentage)	
Description	
Frequency	Annual
Data source	TSG
Methodology for Data Collection	Project reporting
Responsibility for Data Collection	TSG
Number of public health officials and health professionals trained in updated surveillance and emergency management (cumulative) (Number)	
Description	Cumulative number of public health officials and health professionals trained in updated surveillance and emergency management, disaggregated by agency and gender.
Frequency	Annual
Data source	MoHSPP
Methodology for Data Collection	MoHSPP reporting
Responsibility for Data	MoHSPP

Collection	
Component 4 – Project Management, Coordination, and Results Monitoring	
Number of FASTR surveys completed, including consultation meetings between World Bank and Government (cumulative) (Number)	
Description	Cumulative number of bi-annual FASTR surveys completed, including consultation meeting on results held between World Bank and Government
Frequency	Annual
Data source	World Bank
Methodology for Data Collection	World Bank reporing
Responsibility for Data Collection	World Bank
Health facilities constructed, renovated, and/or equipped (cumulative) (Number)	
Description	Cumulative number of PHC facilities constructed, rehabilitated and/or equipped by Project across components 1, 2, and 3.
Frequency	Annual
Data source	TSG
Methodology for Data Collection	Project reporting
Responsibility for Data Collection	TSG
Number of health sector staff trained (cumulative) (Number)	
Description	Number of health staff trained across all Project components
Frequency	Annual
Data source	PIU
Methodology for Data Collection	Project reporitng
Responsibility for Data Collection	MoHSPP
Component 5 - Contingent Emergency Response Component (CERC)	

Verification Protocol: Performance Based Conditions

1 : Policy and institutional reforms for introducing strategic purchasing adopted	
Formula	
Description	The foundations for introducing strategic purchasing of healthcare services will be built. PBT (1.1) (by December 31, 2025): National health service delivery network optimization plan has been developed and approved. PBT (1.2) (by December 31, 2026): Single state guaranteed benefit package (SGBP) for PHC developed, costed, and approved. PBT (1.3) (by December 31, 2026): Staffing norms for PHCs revised and approved. PBT (1.4) (by December 31, 2027): Regulatory framework to increase the PHC providers' autonomy developed and approved. PBT (1.5) (PBT 1.5(a) by December 31, 2027 and PBT 1.5(b) by August 31 2028): Health Services Purchasing Structure established and staffed.
Data source/ Agency	MoHSPP
Verification Entity	IVA
Procedure	PBT (1.1): Verify that the national health service delivery network optimization plan defines: (a) the optimal network and capacity of healthcare facilities to respond to the needs of the population; (b) the volume and scope of services to provide efficiency, quality, and safety of care, has been developed based on the international good practices and adopted according to national legislation and procedures; PBT (1.2): Verify that the single state-guaranteed benefit package (SGBP) for PHC services meets international good practices (as defined in the Project Operations Manual) and that responds to population health needs and disease burden has been developed and adopted according to national legislation and procedures; PBT (1.3): Verify that staffing norms for PHC determine cadre and position needs of PHC facilities by taking into account the results (outputs) of work that were developed and adopted according to national legislation and procedures. PBT (1.4): Verify that regulatory framework that gives PHC providers increased autonomy in (a) financial management; (b) human resource management; (c) procurement of medicines and medical supplies; and (d) management of assets within current legislation (fixed and liquid), that incorporates the findings of the PFM and legal study carried out by the World Bank, has been developed and adopted according to national legislation and procedures.

	PBT (1.5): (a) Verify that: (i) the Health Services Purchasing Structure has been established by a decree issued according to national standard established legislation and procedures; (ii) the multi-year human resources plan has been developed based on international good practices and adopted according to national legislation and procedures and (iii) the Health Services Purchasing Structure has been staffed according to the multi-year human resources plan adopted in 2027. (b) Verify that: the Health Services Purchasing Structure has been staffed according to multi-year human resources plan adopted in 2028.
2 : Electronic Patient Registry (EPR) and Electronic Medical Records (EMR) are functional.	
Formula	
Description	The foundations for digitalizing the information in the PHC network will be built. PBT (2.1) (by December 31, 2026) Electronic Patient Registry (EPR) is functional and integrated with the civil registry; PBT (2.2) (by December 31, 2027) Electronic Medical Records (EMRs) are functional.
Data source/ Agency	MoHSPP
Verification Entity	IVA
Procedure	PBT (2.1): Verify that the (i) EPR is developed as per approved requirements analysis and design specifications, including integration with the civil registry; (ii) EPR is deployed on an MoHSPP provided server; (iii) at least (A) one healthcare worker per each district, city and rural health center facility in Selected Districts 2 and (B) relevant staff at the MoHSPP and the RCMSI have been trained to use EPR; and (iv) each primary healthcare facility in Selected Districts 2 have the infrastructure to use EPR. PBT (2.2): Verify that the (i) EMR is developed as per approved requirements analysis and design specifications; (ii) EMR is deployed on an MoHSPP provided server; (iii) at least (A) one healthcare worker per each district, city and rural health center facility in Selected Districts 2 and (B) relevant staff at the MoHSPP and the RCMSI have been trained to use EMR; and (iv) each primary healthcare facility in Selected Districts 2 have the necessary infrastructure to use EMR.

Note: “Selected Districts 2” means the territory of the municipality of Dushanbe and of the regional sub-division of Sughd.

Annex 1. Project Measures to Address Climate Change

Annex 1 Table: 1 Project Measures to Address Vulnerabilities, Enhance Climate Resilience and Adaptation, and Mitigate Greenhouse Gas Emissions

Project Component and Financing	**Activity**	**Climate-Related Action and how it will adapt to or mitigate against climate change**
Component 1: Quality Improvements through Primary Healthcare Strengthening (US$17.9 million from IDA)		
Subcomponent 1.1 Quality Improvements of Primary Care through Investments in Human Resources and Demand Stimulation *(US$4.6 million from IDA)*	Retention of family medicine doctors and nurses in climate-vulnerable areas	As the Project will develop a retention roadmap to guide human resource investments in climate vulnerable areas based on the master plan that maps out climate-vulnerable areas, this will ensure sufficient capacity to respond to climate-related health risks. Development of the master plan will be supported by this Project. **Adaptation.**
	Train public healthcare workers to respond to climate emergencies and disease outbreaks	The Project will incorporate training of healthcare workers on climate risks in focusing on climate preparedness and prevention measures to minimize increases in diseases following weather events. For example, water and sanitation and infection prevention and control will be incorporated in health worker training to reduce the impacts of diarrheal and infectious diseases which are climate-related. This will help health facilities adapt to the impacts of climate change. Specific training modules and materials on climate emergency preparedness and response will be developed and used. **Adaptation.**
	Development and establishment of an online platform for educating PHC staff	Development and establishment of an online platform for providing continuous education to PHC staff on climate preparedness and disaster response. **Adaptation**. The online learning platform to train PHC staff will additionally reduce the need to travel, reducing carbon emissions. **Mitigation.**
	Mobile outreach with health promotion, prevention, and behavioral change communication	Through enhancing mobile outreach to promote uptake of health services, the Project will also increase the uptake of health services in the event of climate disasters and shocks, thus helping the population, who may not be able to otherwise access health services, to adapt to the impacts of climate shocks. The mobile outreach will be designed based on the master plan that maps climate-vulnerable areas. This will increase the coverage of, and access to, services for climate-sensitive conditions, including diarrhea diseases. **Adaptation.**
	Risk communication on climate hazards	Further, the mobile outreach will include risk communication on climate hazards and measures to take to prevent diseases in the event of climate disasters, such as floods and landslides. Specific climate-related messaging materials will be developed for communication through mobile clinics. **Adaptation.**
Subcomponent 1.2: Quality Improvements of Primary Care through Physical Infrastructure Improvements	Development of health facility energy-efficiency standards	TA will be engaged through the Project to develop new standard designs (**US$100,000**) for PHC facilities that will incorporate energy-efficiency measures, such as maximum use of natural lighting, energy-efficient building design, and, to the extent possible, use of locally sourced materials, to lower the emissions related to buildings and transport-related emissions. Specific measures to be incorporated will be identified by the TA provider. These and other relevant measures will be

Project Component and Financing	Activity	Climate-Related Action and how it will adapt to or mitigate against climate change
(US$13.4 million from IDA).		used to inform the subsequent PHC facility construction (**US$11.94 million** on construction and rehabilitation) under the Project as well as overall in the country going forward. **Adaptation.**
	Construction and rehabilitation of priority PHC facilities	The construction of new PHC facilities (**US$9.47 million**) will increase the number of facilities individuals have access to in the event of climate shocks. The rehabilitation of PHC facilities in remote areas, which are more vulnerable to the impacts of climate change, will ensure that individuals at high risk of negative climate impacts have access to quality PHC facilities and services. Rehabilitation will be based on the same new standard designs as the construction works and include, as appropriate, the respective energy-efficiency approaches. **Mitigation.**
	Climate adaptation measures in PHC facilities	Rehabilitation of PHC facilities (**US$2.47 million)** will include climate-adaptation measures. This will include robust insulation of roofs and walls to keep buildings cool during heat events and reduce requirements for heating in winter, safe water in flood-prone areas; for example, installation of water tanks/towers and/or drilling of boreholes depending on circumstances and individual needs of each selected PHC facility. Such climate adaptation measures in PHC building design will help adapt health facilities to climate shocks including extreme temperatures, droughts, and flooding. Specific measures to be incorporated will be identified by the TA provider. **Adaptation**
	Procurement of PHC equipment	Basic medical and laboratory equipment (**US$2.79 million**) to be purchased through this subcomponent will meet energy-efficiency standards as outlined in the International Electrotechnical Commission (IEC) 60601-1”9,"*Medical Equipment - General requirements for basic safety and essential performance – Collateral Standard: Requirements for environmentally conscious design*,"[68] as long as equipment meeting these standards is either available in country or can be externally procured and transported to the country. Energy Star efficiency standards will be used to assess the energy efficiency of any equipment not covered in the IEC Medical Equipment guidelines. This will contribute to reducing greenhouse gas emissions. **Mitigation.**
	Solarization of PHC facilities	The subcomponent will finance purchase of solar power equipment for at least 61 RHCs to be rehabilitated (**US$687,000**). Use of solar power will contribute to reduced greenhouse gas emissions while increasing access to power at and adaptive capacity of the RHCs. **Mitigation.**
	Energy-saving renovations to PHC facilities	The study of alternative systems for electricity and heating (**US$50,000**) will examine context-appropriate options to provide PHC facilities to be constructed and rehabilitated with independent power supplies where reliable public networks do not exist, especially in hard-to-reach areas and in winter. The study will aim to reduce carbon emissions and, in addition to solar panels, will consider ground- or air-source heat pumps and other options appropriate in the Tajikistan context. Based on the study recommendations, the Project will invest in alternative systems for electricity and heating (**US$500,000**) that are most appropriate to the needs of each specific RHC. **Mitigation.**

[68] https://webstore.iec.ch/publication/67382.

Project Component and Financing	**Activity**	**Climate-Related Action and how it will adapt to or mitigate against climate change**
Component 2: Efficiency-Enhancing Reforms in the PHC Network (US$15.6 million from IDA)		
Subcomponent 2.1: Strategic Purchasing of PHC Services *(US$ 5.3 million from IDA)*.	Revision of benefit package	The revision of the PHC benefit package will ensure equitable distribution of essential medication to climate-vulnerable populations, including those with the highest climate-related disease burden (diarrheas, stunting, etc.). The climate vulnerability will be identified through the service delivery master plan financed by this Project. The benefit package will include emergency services during climatic shocks, such as floods, earthquakes, and landslides. **Adaptation.**
	Development of a service delivery network masterplan/network optimization plan to optimize service delivery	The Project will support the development of a Master Plan (**US$996,750**) mapping out climate-vulnerable areas to enhance the service delivery network for populations with high climate vulnerability Development of the service delivery network masterplan/ network optimization plan will include plans on how to better prevent and treat climate-sensitive diseases, such as typhoid outbreaks or diarrhea that are prevalent in the country. **Adaptation.**
Subcomponent 2.2: Digitalization and Infrastructure Upgrade of the PHC Network *(US$ 10.3 million from IDA).*	Digitization of the PHC network	Digitization of the PHC network, including the development and expansion of EPR and basic EMR (**US$7.61 million**) in PHC facilities, will help improve access to, and availability of, health data during climate shocks – floods, landslides, and droughts, which occur frequently in Tajikistan – thus helping to better reach people in climate-vulnerable areas. This will help health workers make real-time decisions about patient care, facilitate accessing patient records, and enhance government information on health workers, allowing the health system to respond more effectively and adapt to climate shocks. **Adaptation.**
	Procurement of PHC equipment	Basic medical and laboratory equipment (**US$2.69 million**) to be purchased through this subcomponent will meet energy-efficiency standards as outlined in the International Electrotechnical Commission (IEC) 60601-1"9,"*Medical Equipment - General requirements for basic safety and essential performance – Collateral Standard: Requirements for environmentally conscious design,*"[69] as long as equipment meeting these standards is either available in country or can be externally procured and transported to the country. Energy Star efficiency standards will be used to assess the energy efficiency of any equipment not covered in the IEC Medical Equipment guidelines. This will contribute to reducing greenhouse gas emissions. **Mitigation.**
Component 4: Project Management, Coordination, and Results Monitoring (US$6.6 million from IDA)		
Component 4: Project Management, Coordination, and Results Monitoring *(US$6.5 million from IDA)*.	Monitoring and management of climate-related aspects of the Project	This component will finance Project monitoring and management of climate activities; it will be assessed at the same rate as other Project activities. **Adaptation.**

[69] *https://webstore.iec.ch/publication/67382*

Annex 2. Detailed Project Description

1. **The proposed Project has five components that seek to create a healthier nation by improving the quality and efficiency of PHC services in selected districts and strengthening national capacity to respond to health emergencies.** ***Component 1*** will invest in PHC to make the PHC network service-ready. It provides funding for human-resources, equipment, and infrastructure upgrades. It also includes interventions to stimulate the demand for PHC services and health promotion, as well as activities to support the integration of GBV services in the health sector, with a particular focus on the PHC level. It will be implemented in 16 districts with the highest poverty level as the Project financing envelope is not sufficient to cover all districts in the country (selection criteria are explained below). ***Component 2*** will focus on efficiency-enhancing reforms in the PHC network, including support to laying the foundations for introducing strategic purchasing of PHC services and digitalization of the PHC network. All interventions under this component will be conceptualized for nationwide implementation and executed in two pioneer areas (Dushanbe city and Sughd region) during the Project's lifetime. These areas were selected because they are already implementing, on a smaller scale,[70] reforms similar to those proposed in Component 2. The Project will build upon their readiness in terms of service delivery capacity for strategic purchasing as well as the local authorities' eagerness to serve as pioneer areas. ***Component 3*** will focus on strengthening the HEPR system and will improve the capacity to prevent, prepare, and respond to health emergencies. It will be implemented nationwide. ***Component 4*** will finance project management, coordination, and results monitoring and be implemented nationwide. ***Component 5*** (Contingency Emergency Response) aims to improve Tajikistan's capacity to respond to disasters in the event of an eligible crisis or emergency occurring during Project implementation.

2. **Level of poverty, the geographical balance between regions, and avoidance of duplication with other investment projects were the key criteria used to select municipalities/districts for Component 1 and infrastructure investments under Component 2.** Municipality/district selection for Component 1, and for infrastructure investments in pioneer regions under Component 2, was completed using the following methodology: (i) the main selection criteria was the level of poverty. Municipalities/districts were ranked based on poverty rates provided by the Government of Tajikistan; (ii) Project costs for (re-)construction and rehabilitation of infrastructure and equipment of RHCs and DHCs/CHCs were computed using data provided by the Government of Tajikistan; (iii) Municipalities/districts were then chosen according to their poverty ranking – those with the highest poverty rates first – until the budget tentatively allocated for (re-)construction and rehabilitation of PHC facilities under the Project was exhausted. The following qualifications were used:

- Districts already covered by HSIP and the ECDP were excluded. On request of MoHSPP, districts covered by other DPs (e.g., GIZ) were included since other DPs do not cover all facilities in a district. Three districts that had, according to data from the MoHSPP, limited need of infrastructure improvements thanks to partner investments were excluded from the initial selection.
- To achieve geographical balance among regions, at least one district, the poorest from six subregions other than Dushanbe,[71] was chosen for inclusion. As poverty rate was the main selection criteria, it was agreed that Dushanbe city would not be included as a subregion. However, selected facilities in

[70] The World Health Organization, with financing from the European Union, is supporting the MoHSPP with a pilot to implement strategic purchasing of PHC services in five districts of Sughd region. Through the State Unitary Enterprise "Smart City", which was established in 2019, the local executive government authority of Dushanbe city, is transforming the capital into a "Smart City." This has involved elements of advancing with digitalization; for instance, one polyclinic in Dushanbe has been digitalized.

[71] Districts of Republican Subordination (DRS), DRS-Rasht Valley, Gorno-Badakhshan Autonomous Oblast (GBAO), Khatlon-Bokhtar, Khatlon-Kulob, and Sughd.

Dushanbe, in great need of renovation to meet accreditation criteria under Component 2, will be considered for upgrades.

- Selection of districts from GBAO was limited to three districts to take into account the low population density.

Following this methodology, a total of 24 municipalities/districts were selected for Project infrastructure and equipment investments – 16 for Component 1 and 8 for Component 2. Specifically, these are:

Annex 2, Table 1: Selected Districts

Component 1		Component 2	
Khatlon-Kulob	Dangara	Sughd	Aini
Khatlon-Bokhtar	Levakant	Sughd	Shahristan
Khatlon-Bokhtar	J. Balkhi	Sughd	Mastchoh
Khatlon-Bokhtar	Khuroson	Sughd	Panjakent
Khatlon-Kulob	Baljuvan	Sughd	Devastich
Khatlon-Kulob	Muminabad	Sughd	Istravshan
Khatlon-Kulob	Sh.Shohin	Sughd	Buston
Khatlon-Bokhtar	Bokhtar	Sughd	Asht
Khatlon-Bokhtar	Norak	Dushanbe	Selected facilities*
Khatlon-Kulob	Temurmalik		
DRS-Rasht Valley	Sangvor		
DRS	Shahrinav		
DRS	Rasht		
GBAO	Rushon		
GBAO	Roshtkala		
GBAO	Shugnan		

*As poverty rate was the main selection criteria, it was agreed that Dushanbe city would not be included as a subregion. However, selected facilities in Dushanbe, in great need of renovation to meet accreditation criteria under Component 2, will be considered for upgrades.

Component 1: Quality Improvements of Primary Care through Primary Healthcare Strengthening

3. **The objective of this component is to improve the conditions for delivering quality PHC services by making PHC facilities service-ready.** This will be achieved through investments in service delivery capacity (human resources, infrastructure, and equipment) in the 16 selected districts and in interventions to ignite the demand for PHC services among the population as well as health promotion.

Subcomponent 1.1: Quality Improvements of Primary Care through Investments in Human Resources and Demand Stimulation

4. **Subcomponent 1.1 will address the pressing need to invest in human resources working at the PHC level in 16 selected districts.** This component will complement activities in existing strategic documents approved by the government – for example, Medical Personnel Training Program up to 2030, 2021-2025 PHC System Development Plan – with support to develop needed strategic directions to strengthen the workforce at the PHC level. This will be achieved by a review of existing retention policies. Based on this, policies for strengthening the capacity and retention of family medicine doctors and nurses in rural areas will be developed and submitted for the approval of the government. These policies should be sensitive to climate-change impacts and explore financial (asymmetric salary increases for specific

cadres) and non-financial (land plots, free housing, education) incentives for family medicine doctors and nurses and other specialists working in the PHC network in remote areas. These proposals will include ideas on how to optimize the PHC workforce, including potential upskilling of nurses. The subcomponent will support the implementation of identified PHC workforce retention and optimization policies in the 16 target districts, including evaluating the impact of retention policies and workforce optimization roadmap. However, the component will not finance recurrent costs, such as top-up for salaries. The strategic work on human resources will be linked to the revision of the masterplan/network optimization plan under Component 2 to ensure that infrastructure optimization is linked to the availability of human resources.

5. **In-person trainings to strengthen knowledge and management of PHC providers.** This will build on ongoing investments under the HSIP and will finance: (i) six (6) month in-person training of doctors and nurses in family medicine in the 16 selected districts; (ii) a short-term PHC management training for heads of PHC facility networks and RHC directors in selected districts to enhance management and supervision capacities of PHC clinics; (iii) training of healthcare workers on climate risk preparedness and response; and (iv) training of healthcare workers in computer literacy and use of equipment purchased under Subcomponent 1.2. This includes support in updating training content for new trainings on GBV services, antimicrobial resistance (AMR), and climate change. It will also provide support to revise existing training programs for narrow specialists at the PHC level and other training to allow for optimization of the PHC workforce. To allow for all trainings to be delivered in a timely manner, the subcomponent will invest in the Republican Training Center for Family Medicine, including its regional branches, to strengthen their capacity to deliver training to PHC professionals.

6. **Development and establishment of an online platform for providing continuous medical education (CME) at the PHC level.** During the COVID-19 pandemic, PHC workers started to attend CME remotely and this highlighted the need to invest in an online learning management system for continuous learning by healthcare workers at the PHC level. This subcomponent will support the establishment of CME and related requirements, including a digital platform at the PHC level building on existing pilots, the strengthening of delivery of CME at the PHC level, TA to develop academic curricula and professional standards for all specialists working at the PHC level, including an incentive structure – for example, credits – for health workers to attend different CME courses. This platform and online training will allow PHC providers to efficiently access the latest evidence, treatment guidelines, climate hazard preparedness, and management information.

7. **Demand-side investments to improve uptake of services.** Throughout the COVID-19 pandemic, MoHSPP has used SMS-based outreach through Mobile Engage to inform and engage the population in pandemic-related updates. This subcomponent will scale-up Mobile Engage nationwide to improve uptake of PHC services, including health promotion activities, prevention, and behavior-change communications related to essential PHC services for NCDs, RMNCAH-N services, early childhood stimulation and development, adolscent health services, climate-sensitive conditions, and GBV. Mobile Engage will also be used to make citizens aware of MoHSPP's Grievance Redress Mechanism (GRM). This subcomponent will support also other ways to increase awareness and use of the GRM system.

8. **Annual National Patient Survey to measure people's views on, and satisfaction with, healthcare services at the PHC level.** Given that many citizens refrain from visiting PHC services and access health services directly at higher levels of care, it is critical to better understand the demand for PHC services and whether citizens' satisfaction with PHC services is changing over time, as PHC services are strengthened. This will be achieved through financing a National Patient Survey to capture patients' views on care received at the PHC level. The survey will include modules on health-seeking behavior, including

a PHC module that tracks the user's view of the services received and their quality at the PHC level. This survey may, if possible, draw upon other existing nationally representative household surveys that collect data on a regular basis, such as the World Bank-initiated Listening to Tajikistan: Survey of Wellbeing.[72] It is critical for MoHSPP to collect this data to stay tuned to the needs and desires of the population and receive feedback from citizens on a regular basis to inform policy decisions in the health sector.

9. **Integration of GBV services in the health sector with particular focus on the PHC level.** To prepare for implementation of the amended Law on Prevention of Domestic Violence[73], this subcomponent will support the integration of GBV services in the health sector with a particular focus on the PHC level. Currently rooms for victims of GBV are available in maternity hospitals, but few victims use these rooms. To better integrate GBV services, a three-pronged approach will be used that will focus on:

- *The level of national policy development* to support the development of policy options to guide the health sector response to GBV, with a particular focus on the role of the PHC network. This includes consideration of GBV services to be included in the national PHC benefit package. Component 2 will support the revision and costing of the national benefit package. This component will ensure that cost-effective GBV services are considered for inclusion in the benefit package. This includes highlighting evidence about the cost-effectiveness of these interventions and making the case for inclusion of GBV services. The government would ultimately decide regarding what services will be prioritized. Furthermore, support will be provided to strengthen the reporting of GBV cases.
- *The level of the PHC facility* where integration will occur by designing referral pathways between the PHC level and higher levels of care (victim support rooms in maternity hospitals), and by ensuring the provision of GBV services, provided they are included in the PHC benefit package. This includes developing clinical guidelines for these services, and training healthcare workers in GBV victim identification, response, referral, and survivor-centered approaches. The Project will also support consultation within MoHSPP to explore the possibility of including social workers in the GBV response. This has been done successfully in other countries in the region, such as Kazakhstan.
- *The level of the individual* where the Project will, as mentioned previously, support training of healthcare staff in provision of GBV services and conduct outreach to the population to create awareness about GBV and related services available at the PHC level. This includes the use of the Mobile Engage platform to send messages about GBV to the population and setting up an anonymous hotline for GBV victims.

10. **GBV work will also be mainstreamed in other components of the Project.** Under Subcomponent 1.2, the Project will invest in mobile PHC services for remote districts. In this regard, GBV services will be one area of focus. Furthermore, questions related to GBV will be integrated in all surveys supported through the Project, including the National Patient Survey and health facility surveys (SDI and FASTR).

[72] For more information, see https://www.worldbank.org/en/country/tajikistan/brief/listening2tajiImpkistan.

[73]Recently the Parliament recommended amending the Law on the Prevention of Domestic Violence to address previous weaknesses and align it with international good practice.[73] This amended Law is likely to be adopted by Parliament soon. It is, therefore, critical that the proposed Project contributes to its implementation. One way of doing so is to better integrate GBV services within the healthcare system. Healthcare providers are often the first and, sometimes, the only point of contact for GBV survivors, providing them not only with immediate life-saving care, but also acting as a link to other recovery support services. There is strong consensus amongst clinicians of the benefits of GBV and health services integration in reducing mortality and morbidity resulting from GBV. Integrating GBV services within a healthcare setting is, therefore, a critical life-saving intervention. In Tajikistan, the government has supported victim support rooms in maternity hospitals, but the coverage of GBV services is patchy, and the high prevalence of GBV stresses the importance of expanding free access to GBV services through the national healthcare system, particularly at the PHC level.

Successful implementation of this approach will enable the much needed and critical expansion of GBV services to women and girls and to a number of communities that currently are critically underserved in Tajikistan in terms of basic GBV services provision. Cumulatively, the results of the integration of GBV and health at PHC level and policy development at the national level will provide valuable contribution to the Government's and Parliament's efforts to strengthen GBV prevention and response in Tajikistan.

Subcomponent 1.2: Quality Improvements of Primary Care through Physical Infrastructure Improvements

11. **Subcomponent 1.2 will support improvements in physical and digital infrastructure of PHC facilities** through investments in rehabilitation of existing and, where needed, construction of new priority PHC facilities in the 16 selected districts, as well as provision of basic medical/laboratory and computer equipment. Support under this subcomponent will focus on RHCs, which are usually more vulnerable to climate change, and a limited number of DHCs/CHCs, which collectively cover predominant shares of population in their catchment areas. The Project will not invest in HHs as they can be supported by local governments, where needed, in line with recent plans by MoHSPP to concentrate investments and service delivery in rural areas at the RHC level. A two-pronged approach would be used to improve physical and digital infrastructure of the project-supported PHC facilities: (i) Subcomponent 1.2 will comprehensively support rehabilitation/construction, basic equipment, and digitalization of DHCs/CHCs and RHCs identified, using poverty-based criteria, in the districts selected for support under Component 1; and (ii) Subcomponent 2.2 will provide a needs-based package of rehabilitation/renovation/extension works and medical and computer equipment necessary for PHC facilities selected under Component 2 in Sughd region and designated facilities in Dushanbe city to meet requirements for implementation of accreditation, digitalization and strategic purchasing (see Subcomponent 2.2). Construction of new PHC facilities under Subcomponent 1.2 will only be financed if envisaged by the Service Delivery Network Master/Optimization Plan to be developed under Component 2. This subcomponent will aim to ensure basic functionality and capacity of selected PHC facilities to deliver quality PHC services and fulfill requirements for accreditation. By ensuring that PHC staff have good working conditions and basic medical and laboratory as well as computer equipment to provide essential PHC services, it will contribute to improve quality of frontline PHC services and make it more attractive for health workers to work at the PHC level. Following the completion of upgrades to the selected PHC facilities, the Government of Tajikistan and beneficiary local governments will be responsible for further maintenance of the constructed/rehabilitated buildings and equipment provided under the Project.

12. **Construction of priority PHC facilities.** A limited number of new PHC facilities will be constructed in the 16 selected districts. Such facilities will be selected by the established PPG from among the rural health facilities identified for construction in the approved PHC Development Plan – 2026 and based on Health Facility Network Master/Optimization Plan to be revised under Component 2. The number and type of facilities to be selected for construction will be based on a MoHSPP-defined three-tier (highest, medium, lower) priority list and limited to the project budget allocated for civil works. New standard designs for different types of rural health facilities will be developed with support from local or international TA based on requirements to infrastructure, human resources, and equipment in new accreditation standards for PHC providers. Design and costing studies will include provision of all selected facilities with reliable water and power supplies through existing public networks, but independent water and power supplies will be considered where reliable public networks do not exist. This would aim to avoid interruptions caused by increased household consumption of electricity and water, especially in hard-to-reach areas and in winter. For this and to reduce carbon emissions, a study of alternative systems for electricity and heating such as solar panels, ground- or air-source heat pumps, rather than oil or coal,

will be undertaken. Installation of water tanks/towers and/or drilling of boreholes will also be considered, depending on circumstances and individual needs of each selected PHC facility. Such needs may also include the fencing of facility sites to prevent unauthorized construction on these sites and related disputes, as well as repairs to small sections of access roads, if proven critical for population access to services.

13. **In terms of digitalization**, PHC facilities supported under Component 1 would be provided with computers/tablets/smartphones, office equipment, and internet access/local area networks (LAN). Besides the connection of these rural PHC facilities with the central databases under Component 2, the provision of computer equipment and internet access will enable them to use teleconsultations and other digital tools to expand health services and improve accessibility of PHC services. Provision of computer equipment and internet access will also enable communication between primary care doctors and specialists unavailable in rural areas, and in the event of a climate disaster, thereby, enhancing quality of care.

14. **Rehabilitation of existing PHC facilities.** Selection of existing PHC facilities for rehabilitation under Component 1 will be made from among the rural PHC facilities identified for rehabilitation in the PHC Development Plan – 2026 and based on the Health Facility Network Master/Optimization Plan, an MoHSPP-defined three-tier (highest, medium, lower) priority list, available project budget, and an approved facility site survey to identify facilities that can be appropriately rehabilitated. Scoping of required works will be based on a condition survey of the selected facilities following the requirements of the PHC facility standard designs compliant with the new health provider accreditation standards. Design and costing studies as well as digitalization activities for facilities to be rehabilitated will follow the same approach as in the construction of the PHC facilities.

15. **Basic medical and laboratory equipment for PHC facilities.** The PHC facilities to be constructed and rehabilitated with Project support will be provided with basic medical and laboratory equipment, medical furniture, and office equipment and furniture. The types and quantities of such equipment/furniture will be based on MoHSPP-approved lists for each type of PHC facility in line with requirements of health provider accreditation standards. The Project will also support training of staff of beneficiary PHC facilities in computer literacy and in using the provided medical and laboratory equipment, considering staff turnover rate and retention strategies – see Subcomponent 1.

16. **PHC services provision for remote rural areas.** Subject to a joint decision with MoHSPP, investments in mobile PHC services may also be supported to bring health services, including GBV services, closer to people living in remote rural areas. An evidence-based concept of how remotely located facilities and populations can benefit from mobile PHC services will be developed in the first year of Project implementation, with respective investments in the 16 target districts, to follow the recommendations outlined in the concept.

17. **This subcomponent will finance the following activities:** (i) a study of alternative methods of heating and lighting for rural PHC facilities; (ii) preparation of standard designs for all facility types and, subsequently, of working drawings, bills of quantities and specifications for the standard buildings; (iii) facility site surveys and building condition surveys, design and costing studies, preparation of site-specific working drawings for foundations and site works, specifications, and bidding documents for each site or groups of sites; (iv) quality assurance of civil works; (v) costs of obtaining permit/legal documentation for facilities constructed/rehabilitated; (vi) basic medical/laboratory equipment and medical/office furniture

for facilities constructed/rehabilitated; (vii) solar panels and other alternative energy sources; (viii) computer and office equipment, and internet access/local area networks (LAN); and (ix) investments to improve provision of mobile PHC services for remote districts.

Component 2: Efficiency-enhancing Reforms in the PHC Network

18. **Component 2 will support reforms related to strategic purchasing and digitalization of PHC to improve spending efficiency, equity, and financial sustainability of the health system.** The activities financed under this component, for example, accreditation program and strategic purchasing model, will be designed for nationwide implementation. However, during the Project period, PHC digitalization and strategic purchasing in primary care will be implemented only in pioneer regions—Sughd region and Dushanbe city**.** This component has two subcomponents as described below.

Subcomponent 2.1: Strategic Purchasing of PHC Services

19. **Subcomponent 2.1 will build the foundations for introducing strategic purchasing in the health sector and support the establishment of a purchasing structure.** The establishment of a Health Services Purchasing Structure which centrally pools and purchases services from accredited providers carries a number of advantages over the current system in Tajikistan. A single purchaser can pool revenues in a single fund, replacing the current complex and incomplete system of subsidies under which stark healthcare funding inequities across rayons (districts) persist. Also, contrary to the current system where local governments serve simultaneously as financiers of care and employers of healthcare workers, a semi-autonomous Health Services Purchasing Structure tasked with maximizing population health and maintaining budget control has incentive to minimize staff and infrastructure redundancies. By establishing a monopsony, the single payer will have the purchasing power to negotiate advantageous prices for medical supplies, addressing an important shortcoming of the current system where providers and patients commonly procure drugs and other medical products from local retailers at substantive markups. Subcomponent 2.1 will, therefore, finance the establishment of the Health Services Purchasing Structure that will act as a single purchaser of the health care services. This includes financing the conception of the purchasing structure, the creation of the legal framework as well as its establishment, initial staff costs, and capacity building of the purchasing structure. To minimize additional personnel costs, the purchaser will be mainly staffed by relevant civil servants that will be transferred from MoHSPP, MoF, and other relevant government agencies such as MedStat at the national level, and from the local administrations at the regional branches level. Additionally, by the end of the Project, approximately 35 new employees will be hired – see Annex 2, Table 2. By the closing of the Project, all staff costs will be transferred to the government as per the example in the table below. The exact schedule will be specified in the POM. The financing of recurrent expenditures for staff during the first years is motivated by the fact that the expenditures are transitional, as they are supporting a new institution not previously budgeted for by the government. This sub-component will also finance equipment and furniture for the new MoHSPP headquarters building.

Annex 2, Table 2. Example of Purchaser Staffing Needs over Project Period

	Y1	Y2	Y3	Y4	Y5	Y6
Share of operating costs (including staff) for Health Services Purchasing Structure financed through counterpart/government financing (final % will depend on when the Health Services Purchasing Structure is established)	0%	20%	40%	60%	80%	100%
Name						
Chief Executive Officer	2	2	3	3	3	3
Department: Operations management (incl. IT experts)	2	2	4	6	8	8
Department: Finance	1	1	1	2	3	3
Department: Health care benefits and provider payment	4	4	7	8	9	9
Department: User and service provider management	1	1	5	10	10	10
Department: Risk and fraud	0	0	0	1	2	2
TOTAL (new staff)	**10**	**10**	**20**	**30**	**35**	**35**

20. **The subcomponent will finance a number of national foundational activities needed for development and sustainable introduction of strategic purchasing, which are listed below:**

21. **Establishment and operationalizing the purchasing structure.** This includes reviewing and revising legal framework, regulatory instruments, and administrative procedures to define the governance and institutional arrangements for the creation of the Health Services Purchasing Structure that will have key purchasing functions. It encompasses advocacy activities to build support for this change, investments in building the capacity of the purchaser with regional branches, and includes the financing of embedded technical advisors, necessary office equipment, and other efforts to strengthen staff capacity of the purchaser, MoHSPP, State Surveillance Service on Health Sector and Social Protection Activities, and MoF. Establishment of the Health Services Purchasing Structure and introduction of strategic purchasing will change the flow of funds for the health sector. The funds from the state budget will be transferred to the purchaser, and it will use these funds to pay for healthcare services. This change will be gradual. In the beginning, only a small share of the health budget – for example, 10 percent – will be assigned to the purchasing structure. Initially, reimbursement of providers by the purchaser can be budget neutral as, for instance, only the share of the budget that is increasing every year due to GDP growth, can initially be used for purchasing services – reimbursement does not have to cover the full cost. The share of the purchasing structure's budget in the government expenditure for health will grow on an annual basis, for example, by 25 percent every year. Eventually, the purchaser will become the only financier (purchaser) of healthcare services. The state budget will continue to finance infrastructure investments and procurement of the equipment, apart from purchasing of services.

22. **Revision and costing of the PHC benefit package.** To introduce strategic purchasing, a single state-guaranteed benefit package (SGBP) must be defined and costed to make the benefit entitlements and obligations clear for the health authorities (strategic purchaser), providers, and the population. This activity will support revision and costing of the SGBP as well as service delivery standards (see accreditation program below). The revision will factor in existing clinical protocols at the PHC level, and establishment of a transparent process for periodically revising the SGBP and clinical protocols to accommodate changing clinical practice, technological changes, and disease burden. The services included in the SGBP will be evidence-based and aim at equitably addressing the burden of disease in the country – for example, including preventive NCD, RMNCHA-N, climate-sensitive conditions, and GBV

services – and ensuring good value for money. As an effective instrument to improve access to health services and reduce financial barriers, the revised SGBP should include basic essential outpatient drugs, at least, for vulnerable groups. By exempting poor and vulnerable groups from copayments and payments for specific drugs, OOP expenditures can be reduced. This activity will also entail a review of vertical programs that could be integrated in the SGBP at the PHC level.

23. **Development of a Service Delivery Network Master/Optimization Plan to optimize services delivery.** This activity will finance the revision of the 2011–20 health facility Master Plan to support the purchaser in contracting services and rightsizing the service delivery network. It will map existing providers and develop an optimal Service Delivery Network Master/Optimization Plan, based on existing and projected population and existing resources, to ensure that the PHC network reaches Tajikistan's entire population and responds to the current health needs of the population. The plan will define networks of practice with linkages between district hospitals, DHCs, RHCs, and HHs. The plan will also consider options to integrate/repurpose vertical facilities and redundant inpatient facilities to improve spending efficiency. It is envisioned that networks of practice can be implemented through strategic purchasing/provider contracting and, thereby, foster a more patient-centered continuum of care. A networking structure can contribute to improved provider knowledge exchange and group learning to improve the quality of care.

24. **Development and implementation of a regulatory framework for transition from the current input-based PHC payment mechanism to payments based on capitation and outputs, including revision of staffing norms.** To achieve greater equity and efficiency in PHC funding, a detailed roadmap, including regulatory framework, on how to transition from the current system of staffing norms and input-based line-item budgeting to payments based on a single capitation formula and output/performance-based indicators will be developed. The roadmap will need to carefully elaborate on the optimal use of the existing healthcare workforce and formulate new staffing norms to form team-based care models at the PHC level based on the latest global evidence for effective PHC. The World Bank is currently conducting an overarching assessment of regulatory and legal changes, particularly, related to PFM, that are needed to implement strategic purchasing in primary care in Tajikistan. This will be a starting point for developing the roadmap.

25. **Development of contracting mechanism for PHC.** Based on the above-mentioned detailed roadmap, a contracting mechanism for PHC, with provider payments linked to health system objectives, will be developed to formalize agreements between public authorities (national purchaser) and providers. This will build on the work developed under the HSIP-supported performance-based financing scheme and will involve calculating payment rates, defining incentives for provision of quality of care, etc. Additionally, the ongoing work supported by the World Bank-funded ECDP to develop a regulatory framework, under which providers are granted increased autonomy to actively manage funds, will continue under this Project.

26. **Development of a domestic resource mobilization roadmap for the health sector.** This is essential to eventually implement the Law on Health Insurance and to make the efficiency-enhancing reforms sustainable. It will also finance a change management and communication roadmap as well as training of healthcare workers and PHC managers in strategic purchasing.

27. **Introduction of a national accreditation program for PHC providers.** Various DPs have worked with MoHSPP and State Surveillance Service for Health Sector and Social Protection Activities (SSSHSSPA or Khadamot) to develop accreditation standards for PHC. However, the efforts remain fragmented. This activity will build on existing efforts to develop a tiered accreditation system that, in a systematic way, would drive service-readiness and quality of care. The accreditation program will, in the future, be linked to the strategic purchasing mechanism and, thereby, create incentives for quality of improvements in PHC

services. This also includes standardizing equipment and staff requirements at different levels of care. Component 2 will finance development and implementation of the accreditation program at the PHC level, while Component 1 will finance broader quality improvement investments in infrastructure, equipment, and human resources. Accreditation process will be financed by the state budget.

28. **Implementation of strategic purchasing of PHC in pioneer regions.** The core strategic purchasing functions listed above will be developed in the first years of Project implementation. Once those are developed, Sughd region and Dushanbe city will be the pioneer regions, where the new regulation and instruments will be implemented first.

29. **Performance-Based Condition (PBC) 1 – Policy and institutional reforms for introducing strategic purchasing adopted – is linked to this subcomponent and serves to incentivize reform implementation.** PBC 1 rewards the following five results: (i) health service delivery network optimization plan developed and approved; (ii) single, state-guaranteed benefit package (SGBP) for PHC developed, costed, and approved; (iii) staffing norms for PHCs revised and approved; (iv) regulatory framework to increase the PHC providers' autonomy developed and approved; and (v) Health Services Purchasing Structure established and staffed.

Subcomponent 2.2: Digitalization and Infrastructure Upgrade of the PHC Network

30. To provide reliable and quality data for the capitation formula and calculation of outcome indicators, this subcomponent will finance the development and expansion of the EPR (including electronic passports for citizens) and basic EMR in PHC facilities. The EPR is necessary for the implementation of the capitation formula, while the EMR system is needed to provide reliable electronic data for the calculation of outcome indicators by the purchaser. Subcomponent 2.2 will finance the implementation of the EPR and EMR in the two pioneer regions, including the training of healthcare workers and PHC managers in these new systems. Overall, the EPR and EMR will be developed to allow for national level scale-up.

31. **Procurement of computers/tablets/smartphones and internet access/LAN for rural and urban PHC facilities**, as this is essential to implement the EMR and EPR. Equipping rural PHC facilities with computers/tablets/smartphones and internet access will enable them to provide teleconsultations to expand health services and to improve accessibility of PHC services, including in the event of climate disasters. The provision of computer equipment and internet access will also enable communication between PHC doctors and specialists unavailable in rural areas. This sub-component will also finance Business intelligence (BI) software and the development of electronic payment systems that will collect and process data from EPR, EMR, and DHIS (already used by MedStat) for analysis, reporting, and payment.

32. **Development and implementation of EPR at the PHC level and strengthening of performance monitoring of healthcare providers.** This activity, designed under the World Bank supported TEC-19 Project[74], will implement a reliable central system that will allow providers to register PHC patients (patient empanelment). An information interface between the EPR and civil registry will also be developed. This will enable electronic data exchange between these two registries, which will reduce the administrative burden on healthcare providers. The new system will prevent duplication of records and link with EMR to access information on the assignment of individual patients to individual PHC providers

[74] Only technical specifications of the EPR will be developed under TEC-19, the remaining work to design and implement the EPR will be financed by Subcomponent 2.2.

(family medicine doctors). It will also integrate with EMR to access registration data around simple events, like visits. This system/module will allow the implementation of a fairer capitation formula.

33. **Design, development, and implementation of the PHC management dashboard,** which will comprise data on basic infrastructure, equipment, staffing, type of services provided, and catchment population of each PHC facility. The PHC management dashboard aims at supporting with real-time use of data for decision-making on investment and quality improvement as well as general reporting.

34. **Design, development, and implementation of EMR at the PHC level and strengthening performance monitoring of healthcare providers.** EMR will provide reliable data required for the calculation of output indicators for the new PHC payment model. The system will link with the EPR and provide functions to support doctors and nurses in their daily work, allowing registration of visit details and medical records management. It will then report data on outcomes and performance and establish data reporting standards at the PHC level to capture reliable data on the performance and output of providers. The EMR at the PHC level will be piloted and then adapted and introduced nationwide. Building on the EMR, an information interface between the purchaser and a service provider will be established to support the contracting mechanism, including mechanisms for independent audit of self-reported data points that generate payments. Business intelligence (BI) software will also be developed to collect and process data from EMR, EPR, and DHIS (already used by MedStat) for analysis, reporting, and monitoring the performance of providers.

35. **Physical infrastructure upgrades in priority PHC facilities to meet accreditation requirements.** As mentioned above, this activity will provide a limited, needs-based package of rehabilitation/renovation/extension works, furniture, and medical and laboratory equipment necessary for PHC facilities selected under Component 2 in pioneer regions to meet requirements for implementation of accreditation and strategic purchasing. Given the same type of support, albeit at a more limited scope, this activity will be closely coordinated with Subcomponent 1.2 to ensure maximum efficiency, where possible. These investments under Component 2 will also serve to incentivize local stakeholders to implement some of the structural reforms under Component 2, such as the pooling of district-level budgets at higher levels.[75]

36. **PBC 2 – Electronic Patient Registry (EPR) and Electronic Medical Records (EMR) are functional – are linked to this subcomponent and serve to incentivize reform implementation.** It rewards two results: (i) EPR is functional and integrated with the civil registry, and (ii) EMR is functional.

Component 3: Health Emergency Preparedness and Response

37. **The objective of this component is to strengthen the MoHSPP and SES capacity to prevent, prepare, and respond to health emergencies.** The HEPR TF will finance the following:

(i) **TA to conduct a detailed assessment of public health functions of SES,** including existing surveillance and early warning systems at the national and subnational levels to identify strengths and weaknesses.

(ii) **Update of job aids, SOPs, protocols, including sanitary aviation concept.** Based on recommendations from the above-mentioned assessments, this component will finance revisions of the job aids, SOPs, and protocols to strengthen facility indicator-based surveillance as well as integration of detection and response timeliness principles and elements into the national HEPR functions.

[75] The implementation of strategic purchasing will imply that e.g., district-level health budgets will be reduced as pooling of resources will occur at the national level. This can raise concerns among district-level officials. Investments in infrastructure, equipment and human resource can be used to create more supporters for the reform activities proposed under Component 2.

(iii) **Developing of PHC facility-level emergency plans.** It will also support the development of facility-based (PHC) public health emergency plans in the 16 project districts under Component 1, training materials, training-of-trainers, and cascade training to be made available for the sectors involved.
(iv) **Training of health professionals** from MoHSPP, including the Health Analysis Unit (HAU), health emergency specialists, regional health departments, SES, PHC facilities, and the 511 Crisis Hotline. This will cover infection prevention and control (IPC), AMR, updated SOPs and protocols, and conducting regular assessments of preparedness capacity, and training of laboratory workers and epidemiologists.
(v) **Additionally, TA will provide support to strengthening coordination on emergency response, detection, and alerting between the PHC network and SES**. Participation of female health professionals in these trainings will be ensured.
(vi) **Strengthening of laboratory systems of regional SES branches to improve capacity to respond to emergencies** through (a) the procurement of vehicles to transport specimens and samples, (b) the purchase of lab equipment for disease prevention and detection, and (c) rehabilitation of SES's lab facilities.
(vii) **Strengthening community engagement, capacity building, trust building, and public health-focused risk communication.** This includes investments in digital means of communication such as Mobile Engage, usage of mobile system functioning for risk communication and health emergency alerts, strengthening 511 Crisis Hotline to operate during pandemics and public health emergencies, updating and adapting risk communication, and community engagement.
(viii) **TA for costing of a National Action Plan** for implementation of IHR (2005) and its 2-3 priority activities, including dissemination and advocacy for implementation.
(ix) **Upgrades of regional branches of SES and entry points,** including rehabilitation and procurement of equipment.
(x) **Carrying out: (a) procurement of a limited stockpile of emergency goods** and other items required at sanitary quarantine border points, as further specified in the POM; and **(b) rehabilitation of two warehouses** as further specified in the POM for storage of the stockpile and other items.
(xi) **Annual simulation exercises of various types and scales for cross-sectoral capacity building** and to test, validate, and enhance preparedness and response plans, procedures, and systems for all hazards and health emergency capabilities. Starting from the second year of the Project, two simulation exercises will be conducted in 2024 and 2025. The intended participants of these exercises will be identified in consultation with the MoHSPP and key DPs;
(xii) **TA to increase capacity of the MoHSPP to lead, convene, and coordinate assistance related to HEPR.** This will include providing opportunities for MoHSPP and SES staff to participate in various national and international HEPR platforms, study tours, conferences, online forums, and roundtables, as well as organizing national stakeholder/coordination meetings, and advocacy for external and domestic resource mobilization for HEPR.

38. **In all activities, the participation of women in public health emergency management and decision-making will be strengthened** by ensuring gender balance among training participants, in working groups/decision-making bodies, in hiring of consultants and policy experts, and by reporting sex-disaggregated monitoring data.

39. **To increase the effectiveness of domestic and external support, MoHSPP will need to improve the coordination of the efforts and increase collaboration in HEPR/IHR capacities.** Component 3 will build on the efforts of the World Bank-financed HSIP and TEC-19 projects. To ensure complementarity with other funding efforts, this component will establish strong links with the World Bank-financed Central Asia One Health Framework for Action: Protecting Food Systems, Preventing Future Pandemics (which has

been granted funding from the Pandemic Fund) (P179272) and Antimicrobial Resistance Program (P174464); ongoing initiatives focused on COVID-19, HEPR/IHR capacities, AMR, and One Health, which are funded/implemented in Tajikistan by the WHO, UNDP, UNOPS, UNICEF, ADB, CDC, USAID, and other active stakeholders through the Development Coordination Council (DCC) Health Working Sub-Group on Health Emergencies; and other existing coordination mechanisms. Furthermore, Component 3 activities will be supported by policy reforms and actions (prior actions) encouraged by the Catastrophe Deferred Drawdown Option instrument planned to be introduced in Tajikistan. This instrument can support the Government of Tajikistan in critical policy reforms related to building resilience and provide contingent financing for immediate liquidity to respond to pre-agreed types of disasters and crises, supporting the country's preparedness.

Component 4: Project Management, Coordination, and Results Monitoring

40. **Component 4 will finance project management, coordination, and result-monitoring.** This includes operating costs, project audits, verification costs of the Independent Verification Agent, and Project implementation staff such as procurement specialists and financial management specialists, etc. To strengthen policy dialogue, coordination of the sector, and capacity to implement structural reforms, the component will finance the institutional strengthening of MoHSPP and MoF. To allow for capacity building of MoHSPP and MoF, the component will finance TA and training for the establishment of a Health Analysis Unit (HAU) in MoHSPP, and in the area of health financing, primarily targeting the Social Expenditures Directorate in the MoF. During this period, MoHSPP will develop a sustainability plan for the HAU to address past failures. The Social Expenditures Directorate in the MoF will receive the following support: training, capacity building by local and international consultants, equipment, and operational expenditures, to adapt and implement the efficiency-enhancing reforms.

41. **This component will also support nationally and sub-nationally representative health facility surveys to facilitate project monitoring and evaluation (M&E).** The component will finance eight biannual FASTR surveys, from 2024 until the end of the Project period, to collect data on service-readiness, and one endline SDI survey in 2027 to gather information on a wide range of structural and process quality indicators. The baseline SDI survey in 2023/24 and the first two FASTR surveys, one in 2023 and one in 2024 will be financed by Bank-executed funding provided by the GFF. From the third survey wave onward, the FASTR surveys will be implemented by the SSSHSSPA (Khadamot). The endline SDI survey will be implemented by an independent survey firm/organization, which will be selected jointly by MoHSPP and the World Bank. Design and implementation of the SDI and FASTR surveys will be undertaken in close collaboration between MoHSPP and World Bank technical teams, regardless of the source of financing.

42. **The SDI health surveys program collects representative data on service-readiness and quality of healthcare services at national and subnational levels.** SDI data generate a platform for health sector accountability and benchmarking results within and across countries and over time. Since the inception of the program in 2010, 24 surveys have been completed in 20 countries in Africa, Latin America, and Asia, capturing the health and primary education service delivery experience of over 500 million people. The SDI health survey in Tajikistan will measure service delivery across all levels of PHC providers, ranging from HHs to RHCs, DHCs, and CHCs, with a particular focus on measuring facility and provider characteristics as well as the patient experience.

43. **The baseline SDI survey will be the first SDI health survey to take place in Tajikistan.** It will require special considerations and adaptation of the standard SDI tools to the local context. For this adaptation, MoHSPP focal points will collaborate closely with World Bank technical and country office

teams, as well as international and local survey firms, data analysts and sampling experts, and local survey managers contracted by the World Bank. To facilitate the collaboration, a Joint Working Group has been established.

44. **The FASTR surveys collect data on structural quality.** The survey consists of about 45-minute-long phone interviews with nationally or sub-nationally representative samples of PHC facilities and elicits information on services provided, infrastructure, financing, workforce and staffing, supplies, leadership and coordination, community engagement, quality of care, and effects of health system shocks. These surveys aim to: (i) create awareness of acute and chronic challenges in service delivery at the PHC level; (ii) inform and assess reforms through an understanding of effects on service delivery, and (iii) enhance the timeliness of facility surveys by supplementing existing large-scale surveys with rapid-cycle approaches. The GFF has used rapid-cycle monitoring approaches to support ministries of health in 22 low- and middle-income countries to identify challenges in essential health service delivery. The FASTR survey tools will be adapted to the Tajik context by the same collaborative mechanism with the MoHSPP as used for the SDI surveys.

Component 5: Contingent Emergency Response

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

Annex 3. Project Financing Sources by Components and Sub-Components

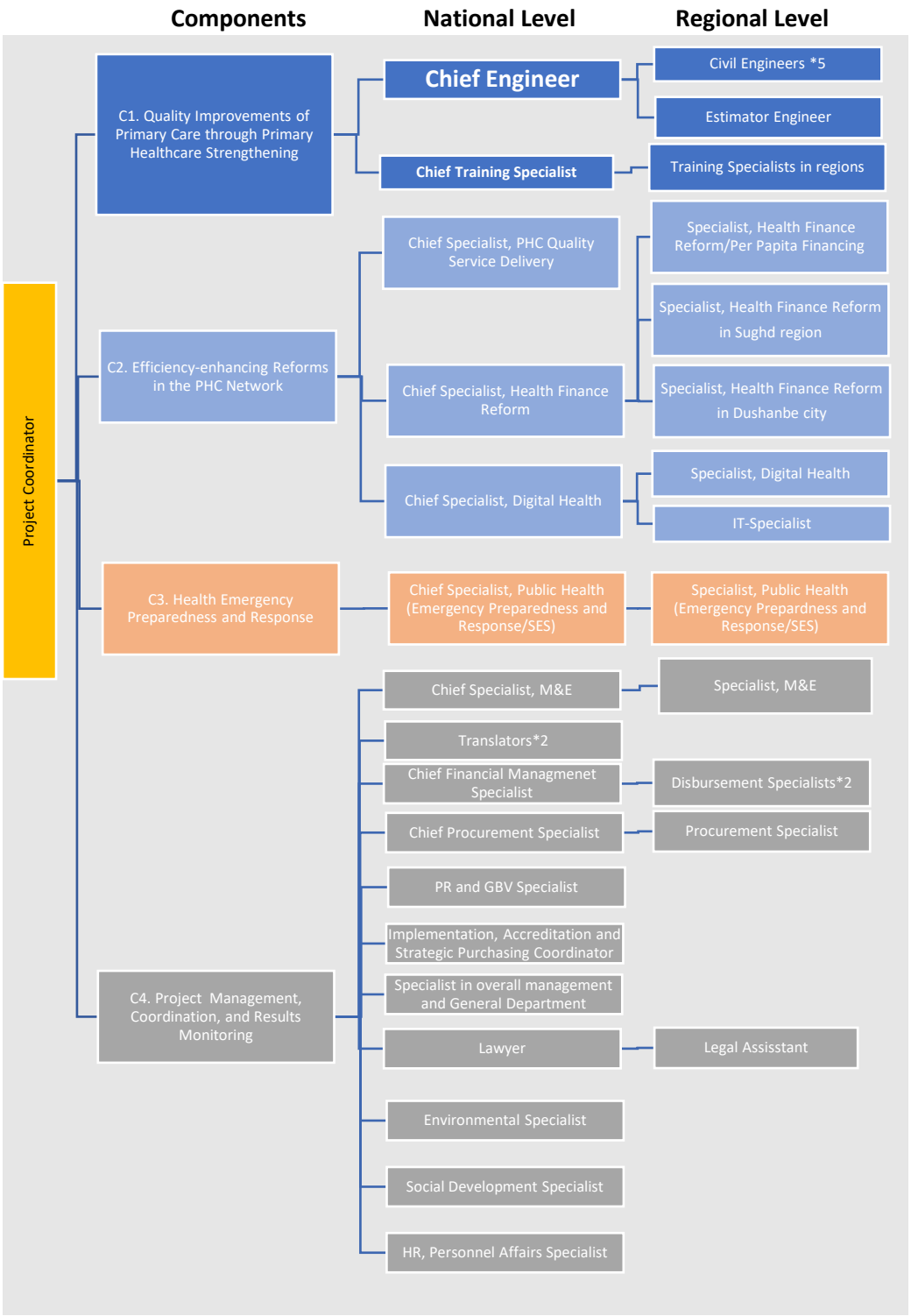
Component Name	Source of Financing				
	IDA	GFF EHS	GFF	HERP	Total
1. Quality Improvements of Primary Care through Primary Healthcare Strengthening	**17,980,400**	**7,341,020**	**200,000**	**0**	**25,521,420**
1.1. Quality Improvements of Primary Care through Investments in Human Resources and Demand Stimulation	*4,597,228*	*2,990,410*	*200,000*	*0*	*7,787,638*
1.2. Quality Improvements of Primary Care through Physical Infrastructure Improvements	*13,383,172*	*4,350,610*	*0*	*0*	*17,733,782*
2. Efficiency-enhancing Reforms in the PHC Network	**15,582,700**	**2,658,980**	**2,175,840**	**0**	**20,417,520**
2.1. Strategic Purchasing of PHC Services	*5,331,986*	*592,163*	*2,175,840*	*0*	*8,099,989*
2.2. Digitalization and Infrastructure Upgrade of the PHC Network	*10,250,714*	*2,066,817*	*0*	*0*	*12,317,531*
3. Health Emergency Preparedness and Response	**0**	**0**	**0**	**4,750,000**	**4,750,000**
4. Project Management, Coordination, and Results Monitoring	**6,436,901**	**0**	**124,160**	**0**	**6,561,060**
5. Contingent Emergency Response	**0**	**0**	**0**	**0**	**0**
Total	***$40,000,001***	***$10,000,000***	***$2,500,000***	***$4,750,000***	***$57,250,000***

Annex 4. Results Chain

Challenge	Activity	**Output**	**Outcome**	**PDO**	**Impact**
Poor access to quality PHC services	Improve PHC workers' skills and retention • Develop and implement roadmap for retention of PHC staff in rural areas • Train PHC staff in family medicine, PHC management, and GBV, and establish an online platform for CME	• PHC workers retention plan implemented • PHC workers trained and with access to online learning	Improved access to and utilization of service-ready PHC facilities and more efficient and equitable distribution of PHC funding	Improved quality and efficiency of PHC services in selected regions	Improved health, reduced mortality, increased human capital, and reduced poverty
	Construct, rehabilitate and equip PHC facilities	PHC facilities constructed/ rehabilitated/equipped			
	Engage citizens to use PHC services	Citizens reached with public health messaging, including on GBV services			
PHC financing inefficiencies and inequities	Support PHC accreditation program	Functional PHC accreditation program developed and implemented			
	Develop and cost single state guaranteed benefit package (SGBP) for PHCs	Evidence-based and feasible PHC SGBP developed, costed, and approved (PBC 1)			
	Create and build capacity of a Health Services Purchasing Structure	Health Services Purchasing Structure has been established and is functional (PBC 1)			
	Develop and implement in pionner regions a plan and regulatory changes needed for transition to PHC strategic purchasing, including change from input-based to blended financing (capitation and output-based payments), and increase in PHC provider managerial autonomy	• PHC facilities contracted by purchaser in pioneer regions under strategic purchasing (PDO). • Regulatory framework to increase PHC provider autonomy approved (PBC 1)			
	Revise PHC facility staffing norms	PHC staffing norms revised and approved (PBC 1)			
Lack of data and capacity for evidence-based decision-making and accountability in PHC	Carry out regular, nationally representative surveys to elicit patient satisfaction and track health facility service-readiness and quality	Frequent data available to identify service-readiness and quality gaps from the health provider and patient perspective	More evidence-based decision-making and greater transparency and accountability for PHC		
	Digitize PHC facilities • Provide required hardware, software, internet access, and training to establish Electronic Patient Registry (EPR) and Electronic Medical Records (EMR) at the PHC level • Establish PHC management dashboard	• EPR is functional and integrated with the civil registry (PBC 2) • EMR are functional (PBC 2) • PHC dashboard established and functional			
	Develop national health service delivery network optimization plan	National health service delivery network optimization plan has been developed and approved (PBC 1)			
	Revitalize Health Analysis Unit in MoHSPP and build capacity in MoF for health financing reforms	Improved capacity for evidence-based decision-making for PHC and beyond			
Lack of health emergency preparedness	Assess and strengthen IHR capacities of SES and MOHSP including: • Train healthcare workers, update of SOPs and protocols, strengthen	Improved capacity to respond to health emergencies including: • Increase in % of SES labs that report data on priority diseases	Increase in percent of health alerts generated by routine or	Strengthened national capacity to respond to	

Challenge	Activity	**Output**	**Outcome**	**PDO**	**Impact**
and response (HEPR) capacity	coordination between PHC network and SES • Conduct annual simulation exercises • Strengthen lab systems, SES regional branches/entry points through rehabilitation and procurement of equipment etc. • Procure stockpile of emergency goods, refurbish warehouses to store emergency goods • Engage communities through public health-focused risk communication • Support costing of the National Action Plan for Implementation of IHRs and investments into 2-3 priority activities, including advocacy and communication. • Build capacity of MoHSPP to lead, convene and coordinate HEPR	• Increase in number of public health officials and health professionals trained in HEPR Number of annual simulation exercises completed National Action Plan for implementation of IHR (2005) costed and priority activities implemented	immediate reporting that receive initial investigation within 72 hours	health emergencies.	

Annex 5: Technical Support Group Composition



Annex 6: Risks and Mitigation Strategies

1. **Political and Governance risk is High.** The implementation of structural reforms under Component 2 will require political leadership at the highest level of government to succeed. While senior government officials have expressed buy-in for these reforms, this risk is assessed as high as difficult political decisions, which involve prioritization between different health services and population groups, would be required for successful implementation of Component 2. To mitigate this risk, the World Bank team has engaged in an inclusive project design process led by the MoHSPP and involving key stakeholders, including at the highest levels of Government—Deputy Prime Minister in charge of social sectors and the Executive Office of the President. This has created an understanding and ownership of health financing and digitization reforms. The Government has also committed to creating a high-level Inter-Sectoral Committee that will provide inter-sectoral project oversight. With regards to governance, and based on experience from similar operations in Tajikistan, corruption and other unethical practices risk directly undermining the achievement of the PDO. This is mitigated by highlighting the importance of closely monitoring Project implementation and creating mechanisms to detect such practices, such as objective monitoring through health facility surveys (FASTR and SDI). The existing sectoral and Project-specific grievance mechanisms will be strengthened to identify and respond to any potential abuses of project resources or beneficiaries. The World Bank task team will closely supervise Project implementation to ensure compliance with World Bank procurement rules and anti-corruption guidelines. There is also a risk related to data openness and transparency, which has been a challenge in the past. This risk will be mitigated by working closely with MoHSPP in the design and implementation of the surveys under the Project and ensuring buy-in at the highest level of government.

2. **Macroeconomic risk is Substantial.** Project outcomes will depend on sufficient allocation of the government budget to the health sector; for example, to maintain and increase recurrent costs, such as salaries for healthcare workers**.** The economic outlook is uncertain, given Tajikistan's high vulnerability to external shocks, particularly those stemming from the high dependence on the Russian economy, as one third of Tajikistan's GDP comprises of remittances from migrant workers working primarily in Russia. However, to date, the expected economic downturn due to the Russia's invasion of Ukraine did not materialize in 2022. Still, geopolitical risks remain high due to the ongoing Russia's invasion of Ukraine, the unresolved border dispute with the Kyrgyz Republic, and the uncertain political situation in neighboring Afghanistan.[76] These uncertainties, particularly potential exchange rate fluctuations and lower demand for Tajik labor in Russia, could lead to escalating prices and reduced fiscal space and could potentially increase the Project costs and thereby undermine the achievement of the PDO. An economic slowdown could also impact counterpart financing of the Project as the government may give priority to other sectors. Strategies to mitigate this risk the project will support the development of a domestic resource mobilization roadmap and there will be an ongoing dialogue with the MoF during project implementation on the importance of allocating sufficient domestic financing to the health sector.

3. **Technical design risk is High.** Component 2 introduces changes to the health financing system that will require challenging policy decisions at the highest levels of Government and by local governments. This is in a context where few civil servants and leaders have deep technical knowledge in health financing and digitization because of limited exposure to similar reform efforts. To mitigate the technical risk, Project preparation teams have participated in study visits to Kazakhstan, Poland, and Türkiye to learn about similar reforms. Efforts to bring up the level technical of knowledge in that regard

[76] World Bank. 2022. *Europe and Central Asia Economic Update, Fall 2022*.

is also ongoing and supported by various DPs, including the EU, WHO, World Bank, and others. These efforts will continue during Project implementation as well as technical support as outlined in the Implementation Arrangements and Support Plan, which is available upon request.

4. **Institutional Capacity for Implementation and Sustainability risk is Substantial.** The main challenge relates to technical knowledge of MoHSPP and MoF in key Project-supported areas, such as health financing and digitization (see technical design risk above). Another key risk relates to sustaining the health financing reform objectives beyond the Project period, as it will take longer than the implementation period to scale-up strategic purchasing of primary care nationwide. To mitigate this risk, ongoing work to mobilize broad stakeholder ownership and engagement, particularly for Components 2 and 3, will be supported throughout the Project period, and counterpart obligations are clearly stipulated in the Project documents. Furthermore, support is and will be provided to MoF to raise domestic financing for the health sector by the World Bank through Bank-executed funding and other DPs, as this is a crucial underpinning to advance purchasing reforms beyond the Project's lifetime successfully. The government's capacity to implement Project activities is good as the TSG staff of the closed HSIP have experience implementing similar activities, and some of these staff are expected to transfer to the Millati Solim Project's TSG. Options have been implemented to maintain key staff during the transition period between the closure of the HSIP on June 30, 2023, and effectiveness of the Millati Solim Project. This risk is still rated Substantial because of the government decree that substantially lowers the project implementation support personnel's salaries from the levels paid during the implementation of HSIP. Therefore, there is a risk that highly-qualified key staff will leave and institutional capacity for implementation will be lost. Further, the MoHSPP Directorate for Sanitary and Epidemiological Safety, Emergency, and Emergency Care, which will spearhead the technical implementation of Component 3, has a track record of successful implementation and resolving complex technical issues during the COVID-19 pandemic.

5. **Fiduciary risk is Substantial** given that several investigations by the World Bank's Integrity Vice Presidency across the Tajikistan portfolio and previous experience from World Bank operations in the sector show there are integrity issues that constantly need to be monitored and mitigated to ensure that Project funds are used to achieve value for money and deliver sustainable results. An important factor to mitigate all fiduciary risks is to ensure that the former staff of the HSIP TSG implement the proposed Project since they have a recent track record of managing fiduciary functions satisfactorily. With regards to specific procurement and financial management risks, no complex procurement and financial transactions are anticipated under the Project, with detailed risk assessments related to this Project outlined below:

- **Procurement risk is Substantial** and is subject to the implementation of the procurement actions described in the Appraisal Summary section. Key issues and risks associated with procurement include: (i) implementing agency not following WB Procurement Regulations due to gaps in knowledge of the procurement procedures; (ii) inadequate procurement capacity of MoHSPP staff to support procurement processing following World Bank Procurement Regulations; (iii) implementation delays during the procurement cycle; (iv) limited skills in contract management resulting in inadequate quality of civil works, and (v) facilities for repair/rehabilitation have not yet been specifically identified. Given the above risks, the following preliminary risk mitigation measures were agreed: (i) a section on procurement procedures and policies will be included in the POM to guide staff in day-to-day procurement operations under the Project; (ii) hiring of procurement specialists with Terms of Reference acceptable to the Bank; (iii) timely planning and monitoring of procurement progress through regular/ monthly meetings and use of eGP system for all contracts subject to

national approach to procurement; (iv) regular monitoring of and reporting on civil works by the Capital Construction Directorate and TSG engineers; and (v) involvement of the Capital Construction Directorate of the MoHSPP and local authorities in the identification of facilities.

- **FM risk is Moderate:** The FM risk is considered moderate, subject to the implementation of the FM actions described in the Appraisal Summary section. The existing FM and disbursement staff contracted by MoHSPP have gained adequate fiduciary experience under ongoing projects and will support the proposed Project. All payments under the Project will be centralized following the World Bank Procurement Regulations or subject to verification when related to achieved PBCs.

6. **Stakeholder risk is Substantial:** This refers to two stakeholder challenges. First, to make a national single Health Services Purchasing Structure functional, with pooling of financing at this level, local governments eventually would need to agree to give up the management of financing to the PHC system at the local level. Local governments that currently control these resources may have grounds to object to changes to the health financing system. To mitigate this risk, the Project has been designed to gradually phase in strategic purchasing and make the initial years of its implementation budget-neutral. Moreover, the Project has been designed to first implement this change in two pioneer areas, Sughd region and Dushanbe city, that are reform prone, willing to participate, and have some experience with similar reforms. Second, an important change required to move more financing to the PHC level from other levels of care is to modify existing staffing norms. Professional associations and labor unions of healthcare workers that are directly impacted by this change may oppose this and disrupt Project implementation. To mitigate this risk, the team will continue to engage at the highest level of government (Executive Office of the President) to explain how this reform will contribute to presidential goals of retaining family medicine doctors and nurses in rural areas and to anchor the reform at this level. The study of other reform efforts that have been successful in Tajikistan – for example, tax reform – shows that it is critical to engage with the highest offices as reforms are implemented using a top-down approach.

7. **Other risks are rated Substantial.** Other risks include risks of natural disasters and climate change. In case of natural disasters, Component 5 may need to be triggered and activated, which would require readjustment and restructuring of the Project. The nature of the Project provides opportunities to directly support climate action, as required by WBG's corporate commitments on climate. Given the nature of the Project, climate resilience-enhancing measures will be prioritized in all activities that will support the construction and rehabilitation of PHC facilities and procurement of equipment – for example, the use of solar panels in the constructed/rehabilitated facilities, including climate-resilience considerations in preparing design documentation and using energy-efficiency criteria in the procurement of equipment. These actions will, by setting an example, contribute to integrating climate action in future construction activities in the health sector.