Report Number: ICRR14291

IEG ICR Review
Independent Evaluation Group

1. Project Data:			Date Posted: 12/17/2013	
Country:	Tajikistan			
Project ID:	P078978		Appraisal	Actual
Project Name:	Community & Basic Health Project	Project Costs (US$M):	16.0	30.77
L/C Number:	CH195; CH461	Loan/Credit (US$M):	10.0	22.91
Sector Board:	Health, Nutrition and Population	Cofinancing (US$M):	6.0	7.86
Cofinanciers:	SIDA, SDC	Board Approval Date:		12/15/2005
		Closing Date:	03/31/2010	12/31/2012
Sector(s):	Health (65%); Central government administration (15%); Compulsory health finance (15%); Other social services (5%)			
Theme(s):	Health system performance (33% - P); Other communicable diseases (17% - S); Child health (17% - S); Administrative and civil service reform (17% - S); Population and reproductive health (16% - S)			

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2. Project Objectives and Components:

a. Objectives:

According to the Development Grant Agreement (DGA, p. 13), the project's objectives were "(a) to increase access to, utilization of, and patient satisfaction with health services in project -supported areas; and (b) to build capacity and efficiency at national, oblast, and rayon levels in administering the basic benefit package and per capita financing for primary health care." The Project Appraisal Document (PAD, p. 3) has essentially the same statement, but refers to "…administering a basic package of health benefits and introducing financing reforms in primary health care."

b.Were the project objectives/key associated outcome targets revised during implementation?

No

c. Components:

The project contained four components:

1. Strengthening policy, planning, and donor coordination in the Ministry of Health (appraisal, US$ 1.46 million; planned with additional financings: US$ 2.70 million; actual, US$ 2.26 million). This component had four subcomponents:

a. Policy formulation and analysis was to include the establishment of a Health Policy Analysis Unit (HPAU) under the MOH's Department of Planning, Coordination, and Implementation of Health Reforms, to perform analytic functions such as monitoring and evaluation of health reforms and provision of evidence -based advice on policy development. It was to include support for the preparation of National Health Accounts (NHA) and a basic sector Medium-Term Expenditure Framework.

b. Strategic and operational planning was to include the development of a comprehensive sector strategy, with the aim of improving the coherence of sector policies and donor-financed activities.

c. Donor coordination was to support MOH through biannual sector review conference that would improve coordination between the government and international donors.

d. Public relations and communication was to strengthen the public relations capacity of the MOH by supporting the operation of an earlier-established Public Relations (PR) unit, ongoing PR activities, and the development of an MOH communications strategy.

2. Implementing organizational and financing reforms in the health sector (appraisal, US$ 4.29 million; planned with additional financings: US$ 5.56 million; actual, US$ 5.42 million). This component had three subcomponents:

a. Strengthening primary health care (PHC) management and financing was to include: (i) management training, furniture, and computers, for newly-formed rayon PHC departments in 41 rayons of the Soghd and Khatlon oblasts (regions); (ii) development of a basic rayon-level PHC management information system (MIS); (iii) an outreach vehicle for each rayon department; and (iv) local technical assistance for the oblast health departments (OHDs) to act as "PHC coaches." These activities were intended to complement a parallel Policy-Based Credit that was designed to strengthen PHC management and financing along with effective implementation of per capita-based budgeting.

b. Strengthening hospital management and implementing the basic program of medical care services was to include, at the hospital level, provision of furniture, computers, training, and basic software for hospital accounting departments; adaptation of a basic health management information system (HMIS) software package to serve billing and receiving functions; and development of business plans. At the oblast level, the subcomponent was to include introduction of a purchasing function in the pilot OHDs; support from local IT consultants; periodic and in-service training of oblast and MOH staff; and local and international TA on fees and patients' rights.

c. Strengthening of MOH oversight of organizational and financial reforms was to include the strengthening of hospital policy development in the Economic and Financial Planning Unit of the MOH by refining output-based budget formulation methods, applying an output-based budget formulation to the development of a medium-term budget framework, and monitoring health financing indicators with the aim of developing baseline NHA.

3. Strengthening primary health care in selected rayons (appraisal, US$ 8.06 million; planned with additional financings: US$ 18.09 million; actual, US$ 19.62 million). This component had three subcomponents:

a. Strengthening the PHC infrastructure envisaged the rehabilitation or replacement of PHC facilities in 2-4 rayons in Sughd and Khatlon oblasts, and furniture and equipment for those facilities.

b. Strengthening PHC services and outreach, financed in parallel by the Swedish International Development Agency (SIDA) was to support: (i) a technically-guided dialogue process between health workers and communities to identify service bottlenecks and plan solutions; and (ii) a small grants program to address the identified issues, with a focus on maternal/child mortality and access to pharmaceuticals.

c. Strengthening PHC training was to include re-training of, at minimum, all PHC workers in project rayons under an approved family medicine training scheme.

4. Project coordination and capacity building for implementation (appraisal, US$ 0.62 million; planed with additional financings: US$ 2.44 million; actual, US$ 3.23 million) was to support project management by a Project Implementation Unit (PIU) to support the MOH in the administration and coordination of the project. Component specialists were to be co-located with their counterparts in the MOH, and over time, the PIU was to become located within MOH as well.

At the time of an Additional Financing from the Global Food Crisis Response Trust Fund in 2008, three new subcomponents were added to the third component: nutritional supplements and nutrition education for pregnant and lactating women; growth monitoring equipment for PHC centers; and food packages for undernourished women at PHC centers. Seven new intermediate outcome indicators were added to the project's results framework to monitor activities under these subcomponents.

d. Comments on Project Cost, Financing, Borrower Contribution, and Dates:

Project Cost: The first component spent 84% of what was originally planned (through the initial plus additional financings), due to cost savings for rehabilitation works and consultancies. The activities under the third component to strengthen PHC spent more than originally planned (through the initial plus additional financings) due to increased costs of civil works, goods, and international consultancy services, and due to rehabilitation of additional facilities. The fourth component spent more than originally planned due to significant increases in operating costs. Overall, over-spending in the third and fourth components was compensated through savings in the first and second components, and overall overspending was due to currency gains due to appreciation of the SDR and Swedish Krona against the US Dollar.

Financing:

Project preparation was supported by a PHRD Grant of US$ 500,000, used for baseline surveys and stakeholder assessment, rationalization and investment plans for rayon health systems in selected rayons, the development of an action plan for community-based health promotion and public health programs operationalization of the community health grant program, development of the Project Implementation Plan and Operational Manual, and other activities. A US$ 300,000 Project Preparation Facility (of which US$240,275 was disbursed, with the remaining amount reallocated to other categories) supported other preparation activities.

The entire project was supported by a total of six grants. The original IDA Specific Investment Loan of US$ 10 million was co-financed by two grants from the Swedish International Development Agency (SIDA, US$ 6.0 million) and Swiss Agency for Development and Cooperation (SDC, US$ 1.2 million). SDC funds were earmarked for components 1c and 3c, as listed above. SIDA financed component 3b. Of these grants, the original IDA grant disbursed US$ 10.62 million, the SIDA grant US$ 6.68 million, and the SDC grant US$ 1.18 million.

Additional Financing (AF) of US$ 4 million from the Global Food Crisis Response Trust Fund was approved on June 13, 2008, with a closing date of March 31, 2010. This AF was an emergency response to the combined impact of the harsh winter of 2007-2008, power shortages, and high energy prices, which resulted in a severe financial and food crisis. This Grant disbursed in full.

IDA AF in the amount of US$ 5 million was approved on May 22, 2009, with a closing date of December 31, 2010, to compensate for overall price inflation due to the financial crisis and to scale up project activities. Two new PDO-level indicators, seven new intermediate outcome indicators, and a modification of one original PDO indicator were approved at this time. Of this AF, US$ 5.19 million was disbursed (with the difference between planned and actual financing due to exchange rate gains).

Another IDA AF in the amount of US$ 3 million was approved in March 2010, with a closing date of December 31, 2012, to further scale up activities. Of this AF, US$ 3.10 million was disbursed.

The first five grants fully disbursed and closed in March 2010. All of the last AF except SDR 548 (which was cancelled) was disbursed by the closing date of that AF, December 2012.

Borrower Contribution: No Recipient contribution was planned or made.

Dates:

In addition to the dates noted above:

In October 2008, US$ 180,000 in original Grant proceeds were reallocated from "Unallocated" to "Operating Costs," due to initially underestimated operating costs and to increased burden of operational costs related to the PIU's parallel administration of the Food Crisis Response AF and preparation of a follow-on health sector support project.

On April 30, 2009, the project was restructured (Level I) to upgrade the project's environmental safeguards category from C to B due to the construction of 11 PHC centers on new sites. This restructuring also extended the project's closing date by nine months, from March 31, 2010 to December 31, 2010, to coincide with the closing date of the first AF.

On August 30, 2010 the project was restructured for a second time (Level II) to reallocate funds in order to reflect funding needs by category more accurately and to use project savings appropriately.

In April 2011, SDR 548 was cancelled from the first AF due to exchange rate gains.

3. Relevance of Objectives & Design:

a. Relevance of Objectives:

Relevance of Objectives is rated Substantial . After the dissolution of the Soviet Union, Tajikistan experienced years of civil war (1993-1997) resulting in severe economic decline, leaving the country one of the poorest in the world. Breakdown in infrastructure and health services, especially in rural areas, led to a resurgence of previously well-managed communicable diseases, including malaria, typhoid fever, and measles . Between 1999 and 2003, Tajikistan experienced a return to peace and stability, bringing modest gains in well -being. However, health spending was still among the lowest per capita in the world (just under $12 in 2003), and the government budget for the health sector in 2003 represented less than one percent of GDP . The health sector was characterized by poor outcomes, misallocation of staff and other resources, inefficient production of care, and hospital overcapacity (the result of an input-based provider payment system). Access to essential services was low due to financial and physical barriers, the latter most pronounced in remote regions and during winter . In 2005, the Government developed a medium-term strategy that focused on: (i) health financing reforms aimed at mobilizing resources to finance essential services; (ii) restructuring of the delivery system to expand the primary health care network based on a family medicine model; (iii) ensuring more effective service delivery for the poor; and (iv) improving transparency and accountability at all levels by promoting participatory policies . These priorities continue to be reflected in the Tajik Comprehensive Health Sector Strategy 2010-2020. The Bank's most recent Country Partnership Strategy (2010-2013) aims to maintain access to critical public services and to strengthen the quality of public services in order to enhance human capital potential . The project's objectives are therefore substantially relevant to country conditions at the time of appraisal, ongoing Government strategy, and current Bank strategy.

b. Relevance of Design:

Relevance of Design is rated Substantial . The project's components addressed key needs of the health sector, as identified in the project's objectives. The PAD (pp. 24-28) contains a results framework clearly, deliberately, and plausibly linking project activities, by component, to the development objectives . The combination of investments in physical infrastructure and intellectual capacity with policy -based budget support were relevant and effective design features. Some minor shortcomings are noted: the planned activities were ambitious, considering the lack of institutional capacity; large number of partners, stakeholders, and funding sources; and dependence of project activities on policy measures to be enacted by the Government (ICR, p. 9). The formation of the HPAU under the first component, however, was plausibly intended to support development of the necessary set of policy measures.

4. Achievement of Objectives (Efficacy):

Increase access to, utilization of, and patient satisfaction with health services in project -supported areas is rated Substantial . The ICR (p. 20) points out that there are several external factors - the 2008-2009 economic crisis, subsequent reduction in household incomes and remittances from abroad, and increases in prices for food and pharmaceuticals - that negatively impacted achievement of this objective. The ICR also points out that, where available, comparison of project and non-project rayons suggests that "the project has an ameliorating impact even if some end-of-project targets might not have been achieved" (p. 20). Even in the absence of these external factors, there is evidence of substantial relative progress along those indicators that compare project with non-project areas. Also, emergency activities related to the food crisis resulted in substantial achievement of anticipated outcomes.

Outputs:

61 facilities in 7 rayons received improved PHC infrastructure, services, and outreach . Other rehabilitated buildings included family medicine training centers and oblast health departments in the Soghd and Khatlon oblasts, and the national MOH and Republican Center of Medical Statistics and Information . Standard design packages were developed for rural health facilities including packages (as appropriate) for photovoltaic energy supply, water supply, disposal of wastewater, and handling and process of solid waste .

290 doctors and 833 nurses in 9 rayons were trained in family medicine, meeting the target of 270 doctors and 838 nurses.

A basic benefits package (Basic Package of Medical Care Services, or BPMCS) was introduced in six hospitals by 2009. The ICR does not provide information on the workings of this package, other than a claim in the Summary of the Borrower's ICR (p. 52) that it would provide financial protection to "privileged category patients" and an implication that it provides for a specified set of free health services. The PAD (p. 37) explains that the BPMCS provides free care for vulnerable populations (defined as exempted from paying for services) and for certain health services for the entire population, most of which are in primary care. 23 seminars on the implementation of BPMCS were held, with participation by 965 specialists. Expansion of BPMCS to other rayons was temporarily put on hold by Government decree in 2011, mainly due to fiscal constraints. (According to the ICR, p. 21, the Government plans to expand BPMCS through a more phased approach in the post-project period.) PHC began to play a gate-keeping role through a referral system.

Two staff were trained in public relations, not meeting the target of 4, but regular public relations and communications campaigns were conducted, and a Public Relations and Communications Strategy for 2007-2010 was developed in 2007. Regular public communications about the health reforms were implemented through television, radio, newspapers, the internet, and press conferences, at the central and oblast levels.

Dialogue between community organizations, health workers, and volunteer networks was established, providing an ongoing framework for communication, prioritization, and micro-planning.

1,195 PHC centers received growth monitoring equipment and logbooks, meeting the target. 433 PHC staff received training on nutrition education and 845 on correct growth monitoring, exceeding the target of 432. 172,562 women pregnant and breastfeeding women received at least one nutrition information session, exceeding the target of 160,000. These 172,562 women represented 100% coverage of all pregnant women in the two oblasts at the time the education sessions were conducted. 50,000 women in the two oblasts received food packages at least three times. According to the ICR's data sheet, this represented 100% of all pregnant women at the cut-off date for compiling the lists of beneficiaries. The ICR does not resolve this discrepancy in the total number of pregnant women. The project team later clarified that these 50,000 women were a select group, not representing all pregnant women in the two oblasts.

Outcomes:

The percentage of households in project-supported areas who did not seek health care when necessary because they could not afford it decreased from 19.7% in 2003 to 15% in 2009 in Soghd, not meeting the target of 6%. In Khatlon, this percentage increased from 13.2% in 2003 to 42% in 2009, not meeting the target of 10%. More recent data are not available due to the discontinuation of the Tajikistan Living Standards Survey after 2009.

The share of health expenditures in total household expenditures decreased in Soghd from 9% in 2003 to 5.95% in 2009, not meeting the target of 4.8%. In Khatlon, this percentage decreased from 9% in 2003 to 6.39% in 2009, not meeting the target of 3.1%. According to the ICR (p. 19), a 2009 Patient Financial Burden and Satisfaction Survey indicated that, when formalized co-payments, informal payments to medical personnel, and payments for drugs and medical supplies were taken into account, the average amount of payment by patients had decreased by 11% in project rayons but increased by 21% in non-project (control) rayons; no detailed information about these survey data is provided.

According to the ICR (p. 19), the number of pregnant women seeking antenatal care increased from zero in 2005 to 2,889 in 2009 and 4,229 in 2012. The ICR does not provide further information on the questionable claim of a zero baseline; the project team later clarified that a baseline was unavailable. The number of home deliveries decreased from 35,063 in 2005 to 21,954 in 2012 in project-supported rayons. The ICR further cites "some improvements" in immunization coverage and infant and child mortality rates (p. 19), but no specific information is provided. The project team subsequently stated that these data are not provided in the ICR because the project did not sponsor activities that would be expected to impact these outcomes, with the possible exception of increased access to health care impacting infant and child mortality.

The number of visits to PHC facilities per capita per year in project-supported rayons was as follows, between 2007/2008 and 2012. The target of a 50% increase from baseline was met or almost met in five of seven rayons, but the number of visits decreased in two rayons.

- Asht: 1.85/1.82, increased to 4.60
- Spitamen: 1.78/1.91, increased to 4.37
- Kabodiyon: 3.60/3.67, decreased to 1.66
- Nurek: 1.75/1.27, increased to 4.00
- Sarband: 3.58/2.94, increased to 5.74

- Shuraabad: 4.65/3.91, decreased to 3.50
- Temurmalik: 2.61, increased to 3.60

The share of hospital admissions of provisionally exempted groups increased from approximately 30% before BPMCS implementation to 43.7% in Sarband, 55.6% in Spitamen, and 65.2% in Nurek in 2011. Deliveries have increasingly constituted the largest share of all admissions of exempted groups . Findings from a patient survey conducted in late 2009, after 15 months of BPMCS implementation, suggest that the share of pregnant women registering with PHC facilities in order to benefit from free delivery under the BPMCS increased from 6.8% to 15% of all PHC visits (ICR, p. 19).

According to the ICR (p. 19), an independent 2010 impact assessment found that the population of project rayons was more satisfied with health services than the population of non -project (control) rayons, but no exact data are provided. Another external evaluation (ICR, pp. 19-20) showed that patient satisfaction at the PHC facility level in some project rayons increased from 58-60% in 2006 to 84-85% in 2009.

Of the women who received nutrition education, 64.3% practiced exclusive breastfeeding for the first six months, from a baseline of 19.8% in Khatlon and 44.5% in Soghd, exceeding the target of 50%.

100% of post-partum mothers received a high-dose vitamin A supplement before their infant reached 8 weeks of age, from a baseline of 44.6% for Khatlon oblast and 46.5% for Soghd oblast, exceeding the target of 70%. 100% of pregnant and breastfeeding women were provided with a prenatal vitamin complex and /or iron folate tablets, from a baseline of 27% for Khatlon and 49% for Soghd, exceeding the target of 70%.

Build capacity and efficiency at national, oblast, and rayon levels in administering the basic benefit package and per capita financing for primary health care is rated Modest, due to limited implementation of both the BPMCS and the capitation scheme.

Outputs:

A Health Policy Analysis Unit was established in the MOH that monitors and evaluates reforms and provides evidence-based advice. A Comprehensive Health Care Strategy for 2010-2020, including strategies for service delivery, resource generation, and governance, was completed and adopted in 2010. A Health Sector Rationalization/Master Plan for 2011-2020 was finalized in December 2010 and adopted by the Government in April 2011. A human resource strategy for 2011-2015 was adopted in 2010. National Health Accounts were first finalized and presented in 2007-2008, and have been presented annually since then . Nine staff were trained in the area of hospital policy development, exceeding the target of 8.

Management and financing of primary care and hospitals were separated in 2006. 75 seminars/roundtables on per capita financing were conducted with the participation of 3,931 managers, economists, local authorities, etc. PHC now plays a gate-keeping function through a referral system. By 2010, all 41 rayon and 2 oblast health departments were provided with management training, furniture, computers, and equipment, and a PHC management information system was put in place for utilization tracking and basic disease surveillance . 26 local oblast-based consultants provided continuous technical assistance and capacity building to rayon PHC management in the areas of health management, financial management, computer literacy, and use of the health management information system. 249 hospitals in all 41 project rayons were equipped with computers and hospital information system software, and 680 managerial, accounting, and health staff were trained in the use of the software. Staff of both oblast health departments were trained to process hospital claims under the Basic Program of Medical Care Services.

Donor coordination has increased through quarterly meetings of a Donor Coordination Council since 2008 and Joint Annual Reviews since 2011. Four Health Summits were held in 2009 and three in 2010.

Outcomes:

Due to fiscal constraints, the Government decided to implement capitation through a phased approach after the project closed. Partial use of a capitation system was achieved in 44 rayons in Soghd and Khatlon oblasts by the end of 2012 (this included the originally planned 41 under the project, plus three for which support from the Asian Development Bank had originally been available but was phased out). The percentage of total PHC expenditure paid by capitation reached 10.2% in Spitamen, 3.8% (average) in Soghd, and 4.4% (average) in Khatlon, not reaching the targets of 100% for Spitamen rayon and 20% for all other rayons in Soghd and Khatlon oblasts. No case-based payments were put in place in hospitals.

The BPMCS (basic benefits package) was introduced in only six hospitals before the aforementioned 2011

Government decree paused its implementation.

5. Efficiency:

Efficiency is rated Modest . The PAD (pp. 55-56) does not conduct a traditional cost-benefit analysis, instead focusing on analyses of fiscal sustainability and likely efficiency gains to the health sector . The ICR (pp. 39-44) conducts a more in-depth analysis, estimating the present value of project benefits at about US$ 17.4 million and the present value of costs at US$ 13.9 million (third component), implying a net benefit of US$ 3.5 million, a benefit/cost ratio of 1.2, and an economic rate of return of 23% (at a 3% discount rate). The assumptions underpinning this analysis are based on a series of estimates, rather than on actual data, that are questionable, especially a reduction of total inpatient days from unnecessary hospital admissions by 30% as a result of enhanced utilization of outpatient care. In fact, even the limited introduction of the basic benefits package in several rayons seems to have increased inpatient utilization by the poor, leading to a possible increase in total hospital admissions. Also, no sensitivity analysis is carried out.

The ICR provides no further direct evidence on the cost-effectiveness of project investments. However, it can be observed that the project scaled down its investments in the basic benefits package and capitation scheme, two of the highest-impact interventions initially planned.

a. If available, enter the Economic Rate of Return (ERR)/Financial Rate of Return (FRR) at appraisal and the re-estimated value at evaluation :

	Rate Available?	Point Value	Coverage/Scope*
Appraisal	No		
ICR estimate	Yes	23%	58%

* Refers to percent of total project cost for which ERR/FRR was calculated.

6. Outcome:

The project's objectives were substantially relevant to country conditions at the time of appraisal, and they remain substantially relevant to Government and Bank strategy. Project design was substantially relevant, plausibly linking planned project activities to intended outcomes and achievement of objectives . The objectives to increase access to, utilization of, and patient satisfaction with health services is considered to have been substantially achieved; even though progress toward targets was uneven, a comparison of project to non-project regions along several indicators suggests that the project's contributions were substantial. However, the objective to build capacity and efficiency at all levels to implement the basic benefits package and capitation was modestly achieved, as these reforms were only partially implemented. Efficiency is rated modest due to questionable assumptions underlying the ICR's economic analysis and lack of further information on cost-effectiveness of the project's investments. Taken together, these ratings are indicative of an outcome rating of Moderately Satisfactory.

a. Outcome Rating : Moderately Satisfactory

7. Rationale for Risk to Development Outcome Rating:

Transition arrangements for continuation of activities funded under the project are adequate, with other donors supporting some MOH functions, some other activities incorporated into routine MOH business, and shared rayon- and oblast-level funding for family medicine training and maintenance of the PHC infrastructure . The ICR contains a fiscal sustainability analysis indicating that recurrent project expenditures represent 0.08% of total public health expenditures. Given the six-fold increase in Tajikistan's economy over the past seven years, significant increase in public health expenditure over the last decade, and positive overall economic outlook, the project's recurrent cost impact is negligible. Institutional development under the project at all levels is likely to be sustained, and the core analytic tools and functions are increasingly being internalized by the MOH . A follow-on Health Services Improvement Project (US$ 15 million, 2013-2019) is to extend the reforms with a focus on improving the coverage and quality of basic primary health services by piloting performance-based financing at the PHC level.

However, some moderate risks remain, including an uncertain policy environment with regard to some of the project's key structural reforms, including capitation and implementation of the basic benefits package, which are not covered by the follow-on project; the Government's ability fully to implement the rationalization plan; and a potential lack of progress in development of the health management information system .

a. Risk to Development Outcome Rating : Moderate

8. Assessment of Bank Performance:

a. Quality at entry:

The project was prepared on a tight timetable (ten months), with much of the preparation budget spent on a Tajikistan Health Sector Note. A Quality Enhancement Review was conducted prior to appraisal, finding the project soundly designed with an adequate balance of ambitiousness and risk . Design built on rigorous analytical work and lessons from the previous project, including the political and technical complexity of rationalizing health facilities, challenges in supervising civil works in remote areas, and the need for policy-based lending to complement investment activities and anchor those activities in the country 's policy context. The project was well designed to leverage complementarities with the Bank 's policy-based operations and the work of other development partners, and collaboration with a wide range of partners during preparation was strong. Preparation and public disclosure of an environmental management plan was done in accordance with best practice, even though the project was category C . However, there were some shortcomings, including deficiencies in the M&E framework and underestimation of risks related to the policy and economic environments. Risks were well defined and mitigated, although the feasibility of scaling up hospitals case-based payment systems and PHC financing reforms in the context of persisting input -based, fragmented financing systems was not fully evaluated at the design stage (ICR, p. 10).

Quality-at-Entry Rating : Moderately Satisfactory

b. Quality of supervision:

Bank-supported programmatic development policy grants reinforced project investments in infrastructure, capacity building, and the establishment of systems and processes . The mid-term review, conducted in 2008 jointly with SIDA and SDC, focused appropriately on ensuring impact and sustainability of project investments and on actions to remedy emerging issues, including modifications to the results framework and reallocation of funds to accommodate rising costs for civil works . The 2008 Additional Financing addressed the impact of sharply rising food prices on the nutritional status of women and children in the two project oblasts. However, the Bank team did not designate alternate monitoring arrangements after discontinuation of the Tajikistan Living Standards Survey in 2009, and it did not adequately manage a period of confusion surrounding target values for key indicators in 2008-2009 (see Section 10b). Also, policy dialogue was not sufficient to carry through full financing and implementation of the basic benefits package and capitation scheme, both of which were key to full achievement of the project 's objectives. According to the ICR (p. 13), there was a lack of convening power to lead the policy dialogue on implementation of structural reforms with the Government at the highest level, and most stakeholders interviewed for the ICR saw this as the Bank 's mandate.

Quality of Supervision Rating : Moderately Satisfactory

Overall Bank Performance Rating : Moderately Satisfactory

9. Assessment of Borrower Performance:

a. Government Performance:

There was strong Government ownership of the project during the early implementation period, reflected in the adoption of an Action Plan for implementation of the Health Sector Financing Strategy in February 2006,

and the establishment of 19 working groups for development of sub-strategies. However, underfinancing of the health sector impeded implementation of the Basic Package of Medical Care Services and the capitation reforms in primary care. Public funding for the health sector increased from 1.3% of GDP in 2006 to 2.0% in 2011, but most of this increase went toward health workers' salaries. Additional public financing for non-salary expenditures, which did not materialize, was critical for full capitation in PHC and effective financing of the benefits package. In addition, overall Government buy-in for the health financing reforms decreased after 2009. Disagreement on health financing reforms between the MOH and Ministry of Finance (MOF) was the main stumbling block to effective implementation and scale-up of these reforms. The MOF was concerned about the lack of a clear, comprehensive vision and implementation capacity for reform at the MOH.

Government Performance Rating Moderately Unsatisfactory

b. Implementing Agency Performance:

According to the ICR, the Project Implementation Unit (PIU) effectively carried out all aspects of project management, even with a change in Director in early 2011. It responded flexibly and efficiently to changing circumstances, including adjustments to procurement and civil works due to the economic crisis. Particularly important was the PIU's exercise of due diligence in supervising civil works at scattered and very remote facilities. The PIU also became effectively involved in policy issues due to lack of technical capacity at the MOH; the PIU also had to be deeply engaged with policy actions taken by the Government due to the dependence of its own work program on those actions.

Implementing Agency Performance Rating : Satisfactory

Overall Borrower Performance Rating : Moderately Satisfactory

10. M&E Design, Implementation, & Utilization:

a. M&E Design:

The project's M&E design had an excessive number of indicators (14 PDO-level indicators and 20 intermediate outcome indicators), many of which were missing baseline and target values. Two main PDO indicators relied on the Tajikistan Living Standards Survey, which was conducted outside the scope of the project, and had baseline and target values set for the national level even though the project covered just selected rayons in two oblasts. Furthermore, some indicators did not reflect project activities; for example, there was an indicator to measure implementation of case-based payments for hospitals, even though hospital payment reform was primarily supported by another donor.

b. M&E Implementation:

Despite shortcomings in M&E design, there was a strong effort to monitor progress toward achievement of objectives. An informal revision of the results framework took place in 2009 to improve the clarity, relevance, and measurability of all indicators. As a result, monitoring of 12 PDO and 14 intermediate outcome indicators was discontinued, and several other indicators were added or refined. A full Level II restructuring of the project in order to revise the entire M&E framework was considered but later rejected, largely due to confusion over original versus revised targets for several key indicators and a resulting mistaken impression that these targets had already been achieved (ICR, p. 14). According to the ICR (p. 14), "this confusion eliminated the last opportunity for correcting deficiencies" in the M&E framework.

c. M&E Utilization:

The MOH has, according to the ICR (p. 14), developed capacity to use data and analysis from the HPAU and other sources for policy planning and decision making. This has been particularly evident since the inauguration of participatory Joint Annual Review conferences in 2011, under MOH leadership.

M&E Quality Rating : Modest

11. Other Issues

a. Safeguards:

The original project was rated category C, as it was limited to the rehabilitation of small PHC facilities within the existing building footprint. No medical wastes were envisaged. Nonetheless, the Recipient prepared, approved, and publicly disclosed in November 2005 an Environmental Management Plan (EMP) covering issues pertinent to small-scale civil works. As part of a Bank-wide portfolio review of investment projects conducted in December 2008, the Bank team discovered that 11 facilities were being built on new sites, with construction already well underway. The Bank team ensured all necessary due diligence by requesting the immediate suspension of all work on new sites and consulting with the Bank's Safeguards Unit. The Safeguards Unit's review found the original EMP to be acceptable, and the project was upgraded from category C to B in March 2009. Subsequently, the Bank team continued to ensure compliance with the EMP and with the Bank 's safeguards policies.

b. Fiduciary Compliance:

The PIU performed all financial management functions as required. Additional internal controls were implemented by the PIU for the Food Price Crisis Additional Financing, as required by the Bank, to ensure transparency and control over the selection of beneficiaries and implementing NGOs. Disbursements under the project were consistently on or ahead of schedule. Although external audit reports were usually submitted in a timely manner and found acceptable by the Bank, the reports for calendar years 2010 and 2011 were delayed due to late selection of an auditor. The ICR does not state whether all audits were unqualified. The project team later confirmed that all audits were unqualified.

Procurement was satisfactory throughout, and the availability of procurement staff in the Bank 's country office enabled regular interaction on procurement issues. Initial delays in the first round of the micronutrient and food packages procurements under the Food Price Crisis Additional Financing occurred due to the increase in procurement workload and lack of technical expertise in the PIU in procurement planning for emergency assistance. This issue was addressed through the recruitment of an additional procurement assistant, collaboration with UNICEF on procurement planning and supply, and application of the simplified shopping method with higher thresholds for the procurement of the first batch of food packages.

c. Unintended Impacts (positive or negative):

None reported.

d. Other:

12. Ratings:	ICR	IEG Review	Reason for Disagreement /Comments
Outcome:	Moderately Satisfactory	Moderately Satisfactory	
Risk to Development Outcome:	Moderate	Moderate	
Bank Performance :	Moderately Satisfactory	Moderately Satisfactory	
Borrower Performance :	Moderately Satisfactory	Moderately Satisfactory	
Quality of ICR :		Satisfactory	

NOTES:
- When insufficient information is provided by the Bank for IEG to arrive at a clear rating, IEG will downgrade the relevant ratings as warranted beginning July 1,

2006.
- The "Reason for Disagreement/Comments" column could cross-reference other sections of the ICR Review, as appropriate.

13. Lessons:

The following lessons are adapted from the ICR (pp. 25-26):

A mix of policy-based budget support and implementation-focused investment lending has the potential to raise the effectiveness of health sector reform interventions. However, when intended policy reforms are not addressed directly by an investment operation, but instead coordinated on a critical path with other Bank operations or programs of other development partners, risk assessments should comprehensively cover and prioritize all elements that can affect the project, including fiscal and capacity constraints and the political complexity of implementing reforms. In this case, failure to anticipate those political challenges led to shortcomings in achievement of development objectives.

In projects involving many partners with common areas of interest, participatory processes and transparency at all stages are critical for sustaining effective coordination and broad support from all stakeholders involved. Such coordination initiatives should be initiated upstream, among the headquarters offices of development partners, at the program planning stage, to avoid constraints in coordination at the country level.

A streamlined results framework and adequate monitoring arrangements are essential to guide implementation and measure results. The preparation and implementation experience of this project demonstrates the critical need for performance indicators to be carefully selected at the design stage, or appropriately revised during implementation. Instead, in this case, the majority of indicators had to be discarded or refined during implementation, with several new ones added, and setting of revised targets (and therefore assessment of outcomes) was complicated by confusion over already-achieved results for two indicators.

14. Assessment Recommended? ○ Yes ● No

15. Comments on Quality of ICR:

The ICR is unusually comprehensive and detailed while still maintaining efficiency of presentation. Effective use is made throughout of footnotes to ensure that important information on project costs, dates, and other details is full included. However, there are shortcomings. The assumptions underlying the economic analysis are questionable. Also, there are many elements of the project that are not clearly explained in the ICR; the reader, for example, has to go back to the PAD to find a basic description of the BPMCS (including the definition of exempted groups) and of the planned capitation scheme.

a.Quality of ICR Rating : Satisfactory