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The World Bank

Report No: ICR1581

IMPLEMENTATION COMPLETION AND RESULTS REPORT
(IDA-H1950; IDA-H4610; IDA-H5860; TF056448; TF090142; TF092349)

ON

INTERNATIONAL DEVELOPMENT ASSOCIATION GRANTS

IN THE AMOUNT OF:

SDR 12.3 MILLION (US$18.0 MILLION EQUIVALENT)

TO THE

REPUBLIC OF TAJIKISTAN

FOR THE

COMMUNITY AND BASIC HEALTH PROJECT

June 28, 2013

Human Development Sector Unit
Central Asia Country Unit
Europe and Central Asia Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective June 28, 2013)

Currency Unit = Tajikistan Somoni
Tajikistan Somoni 1.00 = US$0.21
US$1.00 = 4.72 Tajikistan Somoni

FISCAL YEAR

January 1 – December 31

ABBREVIATIONS AND ACRONYMS

ADB	Asian Development Bank	MOF	Ministry of Finance
AF	Additional Financing	MOH	Ministry of Health
BPMCS	Basic Program of Medical Care Services	MTBF	Medium-Term Budget Framework
CBHP	Community and Basic Health Project	MTR	Mid-Term Review
CME	Continuous Medical Education	NCD	Non-communicable Disease
CPS	Country Partnership Strategy	NDS	National Development Strategy
CRH	Central Rayon Hospital	NGO	Non-governmental Organization
SCISPM	State Committee for Investments and State Property Management	NHA	National Health Accounts
DGA	Development Grant Agreement	OHD	Oblast Health Department
DP	Development Partner	PAD	Project Appraisal Document
EC	European Commission	PDO	Project Development Objective
EMP	Environmental Management Plan	PDPG	Programmatic Development Policy Grant
FM	Family Medicine	PETS	Public Expenditure Tracking Survey
FMTC	Family Medicine Training Center	PHC	Primary Health Care
GFPCR	Global Food Price Crisis Response	PHCP	Primary Health Care Project
GOT	Government of Tajikistan	PIU	Project Implementation Unit
HMIS	Health Management Information System	PPA	Project Preparation Advance
HPAU	Health Policy Analysis Unit	PRS	Poverty Reduction Strategy
HR	Human Resources	QHCP	Quality Health Care Project
HSFS	Health Sector Financing Strategy	RF	Results Framework
ICR	Implementation Completion and Results Report	RMSI	Republican Medical Statistics Institute
IDA	International Development Association	SDC	Swiss Agency for Development and Cooperation
IO	Intermediate Outcome	SIDA	Swedish International Cooperation Agency
ISR	Implementation Status Report	SIL	Specific Investment Lending
IT	Information Technology	TA	Technical Assistance
LDP	Letter of Development Policy	TLSS	Tajikistan Living Standards Survey
M&E	Monitoring and Evaluation	TTL	Task Team Leader
MCH	Maternal and Child Health	UNICEF	United Nations Emergency Fund for Children
MDG	Millennium Development Goals	USAID	United States Agency for International Development
MIS	Management Information System	WHO	World Health Organization

Vice President:	Philippe Le Houérou
Country Director:	Saroj K. Jha
Sector Manager:	Daniel Dulitzky
Project Team Leader:	Wezi M. Msisha
ICR Team Leader:	Baktybek Zhumadil

TAJIKISTAN
Community and Basic Health Project

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A. Basic Information			
Country:	Tajikistan	Project Name:	Community & Basic Health Project
Project ID:	P078978	L/C/TF Number(s):	IDA-H1950,IDA-H4610,IDA-H5860,TF056448,TF090142,TF092349[1]
ICR Date:	06/18/2013	ICR Type:	Core ICR
Lending Instrument:	SIL	Borrower:	REPUBLIC OF TAJIKISTAN
Original Total Commitment:	XDR 6.90M	Disbursed Amount:	XDR 12.30M
Revised Amount:	XDR 12.30M		
Environmental Category: B			
Implementing Agencies: Project Implementation Unit - Health			
Cofinanciers and Other External Partners: Swedish International Cooperation Agency (SIDA), Swiss Agency for Development and Cooperation (SDC)[2]			

B. Key Dates				
Process	**Date**	**Process**	**Original Date**	**Revised / Actual Date(s)**
Concept Review:	02/07/2005	Effectiveness:	04/18/2006	04/18/2006
Appraisal:	06/29/2005	Restructuring(s):		04/30/2009 08/30/2010
Approval:	12/15/2005	Mid-term Review:	11/10/2008	10/07/2008
		Closing:	03/31/2010	12/31/2012

[1] In addition to the three IDA grants, the project benefited from the SIDA and SDC grants (TF-56448 and TF-90142, respectively), which co-financed CBHP, and a grant from the Global Food Price Crisis Response TF (TF-92349) for a total amount of US$ 11.29 M equivalent, of which US$ 11.86 M equivalent was disbursed (refer to Annex 1for details).

[2] Comments from SDC in annex 7

C. Ratings Summary

C.1 Performance Rating by ICR	
Outcomes:	Moderately Satisfactory
Risk to Development Outcome:	Moderate
Bank Performance:	Moderately Satisfactory
Borrower Performance:	Moderately Satisfactory

C.2 Detailed Ratings of Bank and Borrower Performance (by ICR)

Bank	Ratings	Borrower	Ratings
Quality at Entry:	Moderately Satisfactory	Government:	Moderately Satisfactory
Quality of Supervision:	Moderately Satisfactory	Implementing Agency/Agencies:	Satisfactory
Overall Bank Performance:	Moderately Satisfactory	**Overall Borrower Performance:**	Moderately Satisfactory

C.3 Quality at Entry and Implementation Performance Indicators

Implementation Performance	Indicators	QAG Assessments (if any)	Rating
Potential Problem Project at any time (Yes/No):	No	Quality at Entry (QEA):	None
Problem Project at any time (Yes/No):	No	Quality of Supervision (QSA):	None
DO rating before Closing/Inactive status:	Moderately Satisfactory		

D. Sector and Theme Codes

	Original	Actual
Sector Code (as % of total Bank financing)		
Central government administration	15	15
Compulsory health finance	15	15
Health	65	65
Other social services	5	5
Theme Code (as % of total Bank financing)		
Administrative and civil service reform	17	17
Child health	17	17
Health system performance	33	33
Other communicable diseases	17	17
Population and reproductive health	16	16

E. Bank Staff		
Positions	At ICR	At Approval
Vice President:	Philippe H. Le Houérou	Shigeo Katsu
Country Director:	Saroj K. Jha	Dennis N. de Tray
Sector Manager:	Daniel Dulitzky	Armin H. Fidler
Project Team Leader:	Wezi M. Msisha	Peyvand Khaleghian
ICR Team Leader:	Baktybek Zhumadil	
ICR Primary Author:	Baktybek Zhumadil	

F. Results Framework Analysis[3]

Project Development Objectives (from Project Appraisal Document)
The objective was to increase access to, utilization of, and patient satisfaction with health services in project-supported areas, and to build capacity and efficiency at national, oblast and rayon levels in administering a basic package of health benefits and introducing financing reforms in primary health care.

Revised Project Development Objectives (as approved by original approving authority)

The Project Development Objectives were not revised.

(a) PDO Indicators

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
Indicator 1 :	Decrease in percentage of households in project-supported areas who do not seek health care when necessary because they cannot afford it *(original indicator; retained until the project closure with the target value revised under AF2)*			
Value quantitative or Qualitative)	57% of poor households (national average) Soghd: 19.7% Khatlon: 13.2%	47%	Soghd: 6% Khatlon: 10% (TLSS 2011)	Soghd: 15% Khatlon: 42% (TLSS 2009)

[3] PDO (No.1-7) and IO (No.1-20) indicators are original CBHP indicators taken from the table "Arrangements for results monitoring" in Annex 3 of the PAD as the complete set of indicators that had actually been used at outset for project monitoring. Indicators listed in other parts of the PAD's Annex 3 and Supplemental Letter No.2, including some additional ones, were not considered in this analysis because they (i) did not have baseline and target values; (ii) in some cases, had different wording; (iii) in some cases, combined more than one indicator from the "Arrangements for results monitoring" table; and (iv) had not been used for actual project monitoring.

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
	(TLSS 2003)			
Date achieved	30-Jun-2003[4]	31-Mar-2010	31-Dec-2012	31-Dec-2012
Comments (incl. % achievement)	***Partially achieved*** but the 2012 target not met based on 2009 data from TLSS. ***Impossible to measure consistently*** the actual value achieved at project closing due to the discontinuation of TLSS after 2009. National average not available			
Indicator 2 :	Decrease in share of health in household expenditure in project-supported areas[5] *(original indicator; retained until the project closure with the target value revised under AF2)*			
Value quantitative or Qualitative)	9% (TLSS 2003)	6%	Soghd: 4.8% Khatlon: 3.1% (TLSS 2007)	Soghd: 5.95%, Khatlon: 6.39% (TLSS 2009)
Date achieved	30-Jun-2003	31-Mar-2010	31-Dec-2012	31-Dec-2012
Comments (incl. % achievement)	***Partially achieved*** but the 2012 target not met based on 2009 data from TLSS. ***Impossible to measure consistently*** the actual value achieved at project closing due to the discontinuation of TLSS after 2009. National average not available			
Indicator 3 :	More equitable distribution of the health budget through implementation of per capita financing in PHC and case-based payment for hospitals *(original indicator; no longer monitored since the informal revision of the results framework (RF) in May 2009)*			
Value quantitative or Qualitative)	Nil of 41 rayons in Soghd and Khatlon	41 rayons		Partial capitation in 44 rayons; no case-based payment for hospitals
Date achieved	23-Nov-2005	31-Mar-2010		31-Dec-2012
Comments (incl. % achievement)	***Partially achieved***. (no case-based payment for hospitals)			
Indicator 4 :	MOH, other government bodies, and donor community show greater coordination in addressing needs of health sector *(original indicator; no longer monitored since the informal revision of the RF in May 2009)*			
Value quantitative or Qualitative)	No regular, formal coordination forums: e.g. Health Summits	Biannual summits throughout Yr1-5		4 in 2009, 3 in 2010

[4] The Tajikistan Living Standards Survey (TLSS) was conducted in May-June 2003 to examine the level and composition of poverty within the country.

[5] The indicator was re-formulated as "Share of health in household expenditure (overall and by household wealth quintiles)" under AF1; however, in all subsequent project documents—including for AF2—it was specified and monitored only on an overall basis.

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
Date achieved	23-Nov-2005	31-Mar-2010		31-Dec-2012
Comments (incl. % achievement)	***Fully achieved.*** In addition, donor coordination took place through quarterly meetings of the Donor Coordination Council since 2008 and Joint Annual Reviews since 2011. Source: Aide Memoire of the October 2008 Mid-Term Review Mission; PIU/MOH Final Completion Report for 2006-2012, Vol. II, Annex 10; http://www.untj.org/dcc/			
Indicator 5 :	Community at large gains better understanding of MOH's reform program and higher satisfaction with health services *(original indicator)*			
Value quantitative or Qualitative)	n/a	Baseline plus 20 percent		Higher satisfaction, but equivocal data on better understanding
Date achieved	23-Nov-2005	31-Mar-2010		31-Dec-2010
Comments (incl. % achievement)	***Partially achieved.*** Evidence of increased satisfaction with health services in the pilot vs. non-pilot rayons according to external project assessments/studies. Equivocal data on community awareness / understanding: (i) awareness about BPMCS implementation at 57% of all respondents in the BPMCS pilot (Spitamen) rayon prior to the BPMCS piloting in June 2007; (ii) incomplete awareness of reforms among regular citizens in 2010; (iii) awareness of every 2nd respondent (over 52% on average) about BPMCS implementation (Spitamen: 66.6%; Nurek: 49%; Sarband: 42.6%) and better understanding of reforms in the pilot vs. non-pilot rayons. Source: PIU/MOH Final Completion Report for 2006-2012, Vol. I; Impact Assessment of the Community and Basic Health Project, INTRAC & Dynamic Management, September 2010; Analytical Report on Monitoring the Community and Basic Health Project, Association of Scientific and Technical Intelligentsia of Tajikistan, May 2012; Program Document for the PDPG6, September 30, 2012.			
Indicator 6 :	MOH's capacity in area of hospital policy development strengthened *(original indicator; no longer monitored since the informal revision of the RF in May 2009)*			
Value quantitative or Qualitative)	3 trained staff	8 trained staff		9 trained staff
Date achieved	23-Nov-2005	31-Mar-2010		31-Dec-2010
Comments (incl. % achievement)	***Exceeded.*** Source: 9 staff trained in hospital policy development PIU data.			
Indicator 7 :	Community benefits from improved PHC infrastructure, services, and outreach at community level *(original indicator; no longer monitored since the informal revision of the RF in May 2009)*			
Value quantitative or Qualitative)	0 facilities	50 facilities		61 facilities
Date achieved	23-Nov-2005	31-Mar-2010		31-Dec-2012

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
Comments (incl. % achievement)	***Partially achieved.*** 68 buildings replaced/rehabilitated, including 61 PHC facilities in 7 rayons;[6] increased utilization of PHC services in 5 of the 7 rayons (PDO indicator No.8); and community-level outreach model established in 16 rayons (IO indicator No.16). Source: Aide Memoire of the October 2010 Implementation Support Mission; ISR No.10 dated December 10, 2010; PIU/MOH Final Completion Report for 2006-2012, Vol. I.			
Indicator 8 :	Number of visits to PHC facilities per capita per year in project-supported rayons *(included under AF1 and retained under AF2)*			
Value quantitative or Qualitative)	Baseline 2009[7] (2007/2008): Asht: 1.85/1.82 Spitamen: 1.78/1.91 Kabodiyon: 3.60/3.67 Nurek: 1.75/1.27 Sarband: 3.58/2.94 Shuraabad: 4.65/3.91 Temurmalik: 2.61[8]	5 visits[9]	Number of total visits increases by 50% compared to the baseline 2009	Asht: 4.60 (118%) Spitamen: 4.37 (144%) Kabodiyon: 1.66 (-54%) Nurek: 4.00 (165%) Sarband: 5.74 (76%) Shuraabad: 3.50 (-18%) Temurmalik: 3.60 (38%)
Date achieved	01-Jun-2009	31-Dec-2010	31-Dec-2012	31-Dec-2012
Comments (incl. % achievement)	***Partially achieved.*** Source: PIU/MOH Final Completion Report for 2006-2012, Vol. II, Annex 10; national statistical data.			
Indicator 9 :	Number of doctors and nurses trained in family medicine in the project area *(included as PDO indicator under AF1)*[10]			
Value quantitative or Qualitative)	183 doctors, 453 nurses	247 doctors, 573 nurses	Additional 30 doctors, 222 nurses	290 doctors, 833 nurses in 9 rayons
Date achieved	31-Mar-2009	31-Dec-2010	31-Dec-2012	31-Dec-2012

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[6] Other rehabilitated buildings included FMTCs and OHDs in each of the two oblasts, and MOH and Republican Center of Medical Statistics and Information.

[7] Averages of the numbers of visits in 2007 and 2008 were used as the 2009 baseline value.

[8] Civil works and FM training were expanded to this rayon under AF2 in 2011-2012; therefore, actual 2009 data is used as the baseline.

[9] This target value was set in AF1 Project Paper relative to the four visits specified as the baseline based on the reported national average of 3.9 visits in 2008, which was higher than the average of 2.6 visits for the six rural pilot rayons due to the incorporation of higher numbers of visits in urban areas. In subsequent project documents, the target value remained unspecified up until it was set under AF2.

[10] In July 2009, this PDO indicator was replaced with Core Sector Indicator "Health personnel receiving training" and moved to Intermediate Outcome indicators.

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
Comments (incl. % achievement)	***Exceeded.*** Source: PIU/MOH Final Completion Report for 2006-2012, Vol. II, Annex 10.			
Indicator 10 :	Percent of total PHC expenditure paid by capitation in project-supported oblasts *(included as PDO indicator under AF2)*			
Value quantitative or Qualitative)	0%	100% in Spitamen rayon and 20% in each of other 43 rayons in 2 target oblasts		Spitamen: 10.2%; Soghd: average 3.8%, range 1%-19.6%. Khatlon: average 4.4%, range 2.2%-9.3%
Date achieved	31-Mar-2009	31-Dec-2012		31-Dec-2012
Comments (incl. % achievement)	***Not achieved.*** However, the Governmental Decree No.536 dated November 2, 2011 established an action plan for a phased introduction of new financing mechanisms in Soghd oblast starting January 1, 2013, and Joint Instruction of MOF and MOH No.49/237 dated April 25, 2013 provided practical guidance on introduction of full per capita financing in PHC facilities of Soghd oblast starting June 1, 2013. Source: PIU/MOH Final Completion Report for 2006-2012, Vol. II; Aide Memoire of the November 2011 Implementation Support Mission; Program Document for the PDPG6, September 30, 2012.			

(b) Intermediate Outcome Indicators

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
Indicator 1:	A1: Health Policy Analysis Unit established in MOH. HPAU monitors and evaluates health reforms, provides MOH with evidence-based advice *(original indicator)*			
Value (quantitative or Qualitative)	HPAU not established	HPAU established		HPAU established, monitors/ evaluates reforms, provides evidence-based advice
Date achieved	23-Nov-2005	31-Dec-2006		31-Dec-2012
Comments (incl. % achievement)	***Achieved.*** PIU/MOH Final Completion Report for 2006-2012, Vol. I and II.			
Indicator 2:	A2: MOH renews and develops sector strategy and subsectoral strategies with inclusion of key national and international partners *(original indicator; no longer monitored since the informal revision of the RF in May 2009)*			

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
Value (quantitative or Qualitative)	Broad strategy exists, but not updated in >3 years; 2 subsector strategies (health financing and HMIS)	3 new sub-sector strategies		Sector strategy and subsectoral strategies developed and adopted
Date achieved	23-Nov-2005	31-Dec-2009		02-Aug-2010
Comments (incl. % achievement)	***Achieved.*** Comprehensive Health Care Strategy 2010-2020, including three new strategies for (i) service delivery, (ii) resource generation, and (iii) governance completed and approved. Source: Governmental Decree No.368 dated August 2, 2010; Aide Memoire of October 2010 Implementation Support Mission; PIU/MOH Final Completion Report for 2006-2012, Vol. II, Annex 1.			
Indicator 3:	A3: MOH, other government bodies and donor community brought together for biannual sector review conferences to review progress and jointly plan efforts *(original indicator)*			
Value quantitative or Qualitative)	Nil	Biannual summits throughout Yr1-5		4 in 2009, 3 in 2010
Date achieved	23-Nov-2005	31-Mar-2010		31-Dec-2010
Comments (incl. % achievement)	***Partially achieved.*** Source: Aide Memoire of the October 2008 Mid-Term Review Mission; PIU/MOH Final Completion Report for 2006-2012, Vol. II, Annex 10			
Indicator 4:	A4: MOH's public relations capacity strengthened *(original indicator; no longer monitored since the informal revision of the RF in May 2009)*			
Value quantitative or Qualitative)	1 trained staff member	4 trained staff members		2 trained staff members
Date achieved	23-Nov-2005	31-Mar-2010		31-Dec-2010
Comments (incl. % achievement)	***Partially achieved.*** Regular public relations and communication campaigns conducted; Public Relations and Communications Strategy for 2007-2010 developed. Source: PIU/MOH Final Completion Report for 2006-2012, Vol. I.			
Indicator 5:	B1: Calculation and implementation of per capita financing in PHC *(original indicator; reformulated under AF1)*[11]			
Value quantitative or Qualitative)	Nil of 41 rayons in Soghd and Khatlon	41 rayons in Soghd and Khatlon	41 rayons in Soghd and Khatlon	44 rayons in Soghd and Khatlon
Date achieved	23-Nov-2005	31-Mar-2010	31-Dec-2010	31-Dec-2010
Comments (incl. %	***Partially achieved.*** Partial capitation in 44 rayons, including 3 rayons from which ADB support was phased out.			

[11] Under AF1, this IO indicator was re-formulated as "Capitation payment implemented for PHC" (baseline: 15 rayons in 2009; target: 41 rayons in Soghd and Khatlon).

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
achievement)	PHC expenditure paid by capitation in project-supported oblasts less than 100% Source: Aide Memoire of May 2009 Implementation Support Mission; PIU/MOH Final Completion Report for 2006-2012, Vol. II, Annex 2.			
Indicator 6:	B1: Management and finances of PHC separated from that of the hospital at the rayon level *(original indicator; no longer monitored since the informal revision of the RFin May 2009)*			
Value quantitative or Qualitative)	Management and finances are combined	Management and finances are separated		Management and finances are separated
Date achieved	23-Nov-2005	31-Dec-2006		25-Dec-2006
Comments (incl. % achievement)	***Achieved.*** Source: Joint Order of the Ministry of Health and Ministry of Finance No.609 dated December 25, 2006; PIU/MOH Final Completion Report for 2006-2012, Vol. II, Annex 2.			
Indicator 7:	B1: Rayon PHC departments strengthened with management training, furniture, computers, equipment and development of PHC management information system for utilization tracking and basic disease surveillance *(original indicator)*			
Value quantitative or Qualitative)	Nil of 41 rayons in Soghd and Khatlon	41 rayons in Soghd and Khatlon		2 OHDs and 41 rayons in Soghd and Khatlon
Date achieved	23-Nov-2005	31-Mar-2010		31-Dec-2010
Comments (incl. % achievement)	***Achieved.*** Source: PIU/MOH Final Completion Report for 2006-2012, Vol. II, Annex 10.			
Indicator 8:	B1: Rayon PHC management benefit from TA and on-the-job training/supervision provided by oblast health departments *(original indicator; no longer monitored since the informal revision of the RF in May 2009)*			
Value quantitative or Qualitative)	Nil of 41 rayons in Soghd and Khatlon	41 rayons in Soghd and Khatlon		44 rayons in Soghd and Khatlon
Date achieved	23-Nov-2005	31-Mar-2010		31-Dec-2010
Comments (incl. % achievement)	***Exceeded.*** 26 local oblast-based consultants integrated into OHDs' management system under Component B provided continuous TA and large-scale capacity building in health management, financial management, computer literacy and HMIS to PHC networks. Source: Aide Memoire of May 2009 Implementation Support Mission; PIU/MOH Final Completion Report for 2006-2012, Vol. II, Annex 10.			
Indicator 9:	B2: Rayon hospital accounts departments trained for role as collector of fee revenues, provided with furniture, computer and software *(original indicator; no longer monitored since the informal revision of the RF in May 2009)*			
Value quantitative or Qualitative)	Nil of 41 rayons in Soghd and Khatlon	41 rayons in Soghd and Khatlon		41 rayons in Soghd and Khatlon
Date achieved	23-Nov-2005	31-Mar-2010		31-Dec-2010
Comments	***Achieved.*** 249 hospitals in 41 rayons in Soghd and Khatlon oblasts equipped			

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
(incl. % achievement)	with computers and hospital HMIS software, and 680 managerial, accounting, and health staff trained in utilization of HMIS. Source: PIU/MOH Final Completion Report for 2006-2012, Vol. II, Annex 10 and ISR No.14 dated December 10, 2012.			
Indicator 10:	B2: Oblast health departments trained to process hospitals' BPMCS payment claims, provided with computers, servers, software and IT consultants *(original indicator; no longer monitored since the informal revision of the RF in May 2009)*			
Value quantitative or Qualitative)	Nil of 2 OHDs in Soghd and Khatlon	Both OHDs		Both OHDs
Date achieved	23-Nov-2005	31-Mar-2010		31-Dec-2010
Comments (incl. % achievement)	***Achieved.*** Source: PIU/MOH Project Implementation Report for 2006-2008 (MTR), Annex 17.			
Indicator 11:	B2: General public better informed about their rights under BPMCS and opportunities for redress in cases of abuse through radio spots, newspaper advertisements, etc. *(original indicator; no longer monitored since the informal revision of the RF in May 2009)*			
Value quantitative or Qualitative)	Sporadic public information efforts by MOH	Quarterly public information efforts		Daily/weekly/monthly/quarterly public information efforts
Date achieved	23-Nov-2005	31-Mar-2010		31-Dec-2010
Comments (incl. % achievement)	***Achieved.*** Awareness about BPMCS implementation at 57% of all respondents in the BPMCS pilot (Spitamen) rayon prior to the BPMCS piloting in June 2007; awareness of every 2nd respondent (over 52% on average) about BPMCS implementation in three pilot rayons (Spitamen: 66.6%; Nurek: 49%; Sarband: 42.6%) and better understanding of the essence of reforms in the pilot vs. non-pilot rayons in 2011. Source: Aide Memoire of the October 2010 Implementation Support Mission; PIU/MOH Final Completion Report for 2006-2012, Vol. I; Analytical Report on Monitoring the Community and Basic Health Project, Association of Scientific and Technical Intelligentsia of Tajikistan, May 2012.			
Indicator 12:	B3: MOH capacity to track community satisfaction and the effectiveness of public expenditure improved through community surveys, PETS *(original indicator; no longer monitored since the informal revision of the RF in May 2009)*			
Value quantitative or Qualitative)	Nil	Three patient satisfaction surveys, two PETS		Three patient satisfaction surveys, no PETS
Date achieved	23-Nov-2005	31-Mar-2010		30-Sep-2009
Comments (incl. % achievement)	***Partially achieved.*** One baseline and two follow-up patient financial burden / satisfaction surveys completed; PETS excluded from CBHP. Source: Aide Memoire of the February-March 2007 Implementation Support Mission; PIU/MOH Final Completion Report for 2006-2012, Vol. II, Annex 10.			
Indicator 13:	B3: MOH capacity to link strategic objectives with budget allocations			

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
	strengthened through development of MTBF that reflects sector and subsector strategies and increased emphasis on PHC and the BPMCS *(original indicator; no longer monitored since the informal revision of the RF in May 2009)*			
Value quantitative or Qualitative)	No MTBF	First full sector MTBF		MTBF completed
Date achieved	23-Nov-2005	31-Dec-2009		31-Dec-2010
Comments (incl. % achievement)	***Achieved.*** First MTBF developed with CBHP input, EC support, and involvement of HPAU. Source: Aide Memoire of the August 2008 Implementation Support Mission; PIU/MOH Project Implementation Report for 2006-2008 (MTR), Annex 17; PIU/MOH Final Completion Report for 2006-2012, Vol. I.			
Indicator 14:	C1: Standard design packages developed for rural health facilities, including, as appropriate, packages for photovoltaic energy supply, water supply, disposal of wastewater and handling and processing of solid waste *(original indicator; no longer monitored since the informal revision of the RF in May 2009)*			
Value quantitative or Qualitative)	Nil	Standard design packages developed		Standard design packages developed
Date achieved	23-Nov-2005	31-Dec-2006		01-Aug-2008
Comments (incl. % achievement)	***Achieved.*** Five types of standard design packages (type A, A*, Б, В, НН) for rural PHC facilities developed and endorsed. Source: PIU/MOH Project Implementation Report for 2006-2008 (MTR)			
Indicator 15:	C1: At least 50 PHC facilities in two rayons in Soghd and Khatlon oblasts rehabilitated or replaced *(original indicator)*[12]			
Value quantitative or Qualitative)	Nil	50 PHC facilities	61 facilities/buildings	68 buildings, incl. 61 PHC facilities
Date achieved	23-Nov-2005	31-Mar-2010	31-Dec-2012	31-Dec-2012
Comments (incl. % achievement)	***Exceeded.*** 68 buildings replaced/rehabilitated, including 61 PHC facilities.[13] Source: PIU/MOH Final Completion Report for 2006-2012, Vol. I.			
Indicator 16:	C2: Regular dialogues commenced and ongoing between health workers and communities to identify service delivery bottlenecks and prioritize solutions *(original indicator; no longer monitored since the informal revision of the RF in May 2009)*			

[12] Although no project-specific indicators were included under AF1 and AF2 to track the number of rehabilitated or replaced PHC facilities, the AF1 target of repairing Soghd Oblast Health Department premises renovating 2 PHC facilities as well as the AF2 target of reconstructing 7 PHC facilities (refer to Annex 10) were continued to be monitored through the Core Sector Indicator "Number of facilities constructed, renovated and equipped".

[13] Other rehabilitated buildings included FMTCs and OHDs in each of the two oblasts, and MOH and Republican Center of Medical Statistics and Information.

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
Value quantitative or Qualitative)	Nil {**nb**: this activity was done in parallel by SIDA}	Regular dialogues commenced and ongoing		Regular dialogues commenced and ongoing
Date achieved	23-Nov-2005	31-Mar-2010		31-Dec-2012
Comments (incl. % achievement)	***Achieved.*** A model for regular dialogues, prioritization and micro-planning (community organizations-volunteer networks-health workers) established and functioning in 16 pilot rayons with support from SIDA-financed TA from three international NGOs (AKTED, Aga Khan Foundation, Mercy Corps) and a small grants program, and CBHP-financed coordination / facilitation at national and oblast levels by three local consultants. All the three NGOs continued their work in the same oblasts beyond the end of the project. Source: PIU/MOH Final Completion Report for 2006-2012, Vol. I; PIU data.			
Indicator 17:	C3: All PHC workers in project rayons retrained under approved family medicine training scheme *(original indicator, continued to be monitored under AF1 and AF2 under different formulations)*[14]			
Value quantitative or Qualitative)	Nil of 6 pilot rayons in Soghd and Khatlon	176 doctors, 496 nurses in 6 rayons	270 doctors, 838 nurses in 9 rayons (CBHP 176/496, AF1 64/120, AF2 30/222)	290 doctors, 833 nurses in 9 rayons (CBHP 196/515, AF1 64/120, 30/198)
Date achieved	23-Nov-2005	31-Mar-2010	31-Dec-2012	31-Dec-2012
Comments (incl. % achievement)	***Exceeded.*** Source: PIU/MOH Final Completion Report for 2006-2012, Vol. I and II.			
Indicator 18:	D: Establishment of Project Implementation Unit consisting of director, finance officer, procurement officer and procurement assistant *(original indicator; no longer monitored since the informal revision of the RF in May 2009)*			
Value quantitative or Qualitative)	Pending	Established (Yr1)		Existing PIU of PHCP retained for CBHP through Yr7
Date achieved	23-Nov-2005	31-Dec-2006		31-Dec-2012
Comments (incl. % achievement)	***Achieved.***			

[14] Under AF1, this IO indicator was re-formulated as “Family medicine training expanded to 2 more rayons” (target: 184 staff in 2 additional rayons), and “Number of doctors and nurses trained in family medicine in the project area” with respective target was also included as PDO indicator. Although no project-specific indicators were maintained under AF2 to track family medicine training, the AF2 target of training 30 doctors and 222 nurses in family medicine in three additional rayons and providing continuing medical education for 280 doctors and 857 nurses previously trained in family medicine (refer to Annex 10) was continued to be monitored through the Core Sector Indicator “Health personnel, receiving training”.

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
Indicator 19:	D: Field supervisors hired as local consultants to oversee civil works *(original indicator; no longer monitored since the informal revision of the RF in May 2009)*			
Value quantitative or Qualitative)	Nil	Hired (Yr1)		Hired and retained through Yr7
Date achieved	23-Nov-2005	31-Dec-2006		31-Dec-2012
Comments (incl. % achievement)	***Achieved.*** Field coordinators selected in Yr1 and hired by the start of full-scale implementation of civil works in Yr2 (May 2007). Source: Aide Memoire of the May 2006 Project Launch Mission.			
Indicator 20:	D: Comprehensive project monitoring reports submitted twice a year *(original indicator; no longer monitored since the informal revision of the RF in May 2009)*			
Value quantitative or Qualitative)	Two per year	Two per year Yr1 through Yr5		Two per year Yr1 through Yr7
Date achieved	23-Nov-2005	31-Mar-2010		31-Dec-2012
Comments (incl. % achievement)	***Achieved.*** Project monitoring reports submitted as required, including updated status for all the agreed monitoring indicators.			
Indicator 21:	C3: Number of PHC staff who received training on nutrition education and correct growth monitoring *(included under Food Price Crisis Response AF)* [15]			
Value quantitative or Qualitative)	None	432		433 on rational nutrition, 845 on correct growth monitoring
Date achieved	17-Jul-2008[16]	31-Mar-2010		31-Mar-2010
Comments (incl. % achievement)	***Exceeded.*** Source: PIU data and ISR No.14 dated December 10, 2012.			
Indicator 22:	C4: Number of post-partum mothers who received a high-dose vitamin A supplement before their infant reached 8 weeks of age *(included under Food Price Crisis Response AF)*			
Value quantitative or Qualitative)	Khatlon oblast: 44.6% Soghd oblast: 46.5%	70%		100%
Date achieved	31-Oct-2005	31-Mar-2010		31-Mar-2010
Comments	***Exceeded.*** 20,000 in Soghd and 30,000 in Khatlon, which represented 100%			

[15] For indicators 21 to 27, the 2005 baseline data is from UNICEF MICS (field work completed in October 2005), and the 2003 baseline data is from UNICEF National Nutrition Survey (survey completed in September 2003).

[16] Date of the Food Price Crisis Response Trust Fund Grant Agreement (TF092349).

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
(incl. % achievement)	coverage of all pregnant women in those oblasts at the cut-off date of compiling the lists of beneficiaries. Source: AF2 Supplemental Letter No.2.			
Indicator 23:	C4: Number of pregnant and breastfeeding women provided with prenatal vitamin complex and/or iron-folate tablets *(included under Food Price Crisis Response AF)*			
Value quantitative or Qualitative)	Khatlon oblast: 27% Soghd oblast: 49% (2003)*[17]	70%		100%
Date achieved	30-Sep-2003	31-Mar-2010		31-Mar-2010
Comments (incl. % achievement)	***Exceeded.*** 20,000 in Soghd and 30,000 in Khatlon, which represented 100% coverage of all pregnant women in those oblasts at the cut-off date of compiling the lists of beneficiaries. Source: AF2 Supplemental Letter No.2.			
Indicator 24:	C4: Number of pregnant and breastfeeding women who received at least one formal nutrition education session *(included under Food Price Crisis Response AF)*			
Value quantitative or Qualitative)	None	160,000		172,562
Date achieved	17-Jul-2008	31-Mar-2010		31-Mar-2010
Comments (incl. % achievement)	***Exceeded.*** 172,562 (47,824 in Soghd, 124,738 in Khatlon), which represented 100% coverage of all pregnant women in those oblasts at the time of conducting the nutrition education sessions. Source: AF2 Supplemental Letter No.2.			
Indicator 25:	C4: Percent of women who received nutrition education and practice exclusive breastfeeding for first 6 months *(included under Food Price Crisis Response AF)*			
Value quantitative or Qualitative)	Khatlon oblast: 19.8% Soghd oblast: 44.5% (2005)~[18]	50%		64.3%
Date achieved	31-Oct-2005	31-Mar-2010		31-Mar-2010
Comments (incl. % achievement)	***Exceeded.*** Source: PIU/MOH Final Completion Report for 2006-2012, Vol. II, Annex 10; Konsultpro Report dated October 2009; ISR No.14 dated December 10, 2012.			
Indicator 26:	C4: Number of PHC centers provided with growth monitoring equipment *(included under Food Price Crisis Response AF)*			
Value quantitative or Qualitative)	None	1,195		1,195
Date achieved	17-Jul-2008	31-Mar-2010		31-Mar-2010

[17] *Baseline data represents reported use of iron folate tablets among non-pregnant women.
[18] ~Baseline data represents % of children under 6 months of age exclusively breastfed.

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
Comments (incl. % achievement)	***Achieved.*** All 1,195 of PHC facilities received instruments and log-books for the child development monitoring, and all the received goods were used for their purpose. Source: Konsultpro Report dated October 2009 and ISR No.14 dated December 10, 2012.			
Indicator 27:	C5: Number of pregnant women who received food packages *(included under Food Price Crisis Response AF)*			
Value quantitative or Qualitative)	None	50,000		50,000 (each three times): 20,000 in Soghd, 30,000 in Khatlon
Date achieved	17-Jul-2008	31-Mar-2010		31-Mar-2010
Comments (incl. % achievement)	***Achieved.*** 20,000 in Soghd and 30,000 in Khatlon, which represented 100% of all pregnant women in those oblasts at the cut-off date of compiling the lists of beneficiaries. Source: PIU data and ISRNo.14 dated December 10, 2012; AF2 Supplemental Letter No.2.			
Indicator 28:	A1: MOH completes one year of NHA *(included under AF1)* [19]			
Value quantitative or Qualitative)	No NHA	NHA for 2008 and 2009 finalized and presented		First NHA report for 2007-2008 finalized and presented
Date achieved	22-May-2009[20]	31-Dec-2010		31-Dec-2010
Comments (incl. % achievement)	***Achieved.*** Source: PIU/MOH Final Completion Report for 2006-2012, Vol. I and II.			
Indicator 29:	A2: MOH completes Health Sector Rationalization / Master Plan *(included under AF1)*			
Value quantitative or Qualitative)	No master plan	Master plan finalized and presented to Government		Master plan finalized and adopted
Date achieved	22-May-2009	31-Dec-2010		01-Apr-2011
Comments (incl. % achievement)	***Achieved.*** Strategic Plan for Rationalization of Health Facilities of the Republic of Tajikistan for 2011-2020 finalized in December 2010 and adopted through the Government Decree No.169 on April 1, 2011.			
Indicator 30:	A2: MOH completes Human Resource strategy with implementation plan *(included under AF1)*			
Value quantitative or	No HR strategy	HR strategy finalized and		HR strategy developed and

[19] Indicators No.28-34 and their baseline and target values were taken verbatim from the Project Paper dated April 7, 2009 for the first Additional Financing.
[20] Date of the Supplemental Letter No.2 for the first Additional Financing.

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
Qualitative)		presented to Government		endorsed by the Ministry of Health
Date achieved	22-May-2009	31-Dec-2010		31-Dec-2010
Comments (incl. % achievement)	***Achieved.*** Program for Development of Human Resources in the Health Sector of the Republic of Tajikistan for 2011-2015 with Implementation Plan and Monitoring and Evaluation Plan developed and acknowledged acceptable to MOH. Source: Ministry of Health letter dated December 15, 2010.			
Indicator 31:	C1: PHC centers equipped with communication system *(included under AF1)*			
Value quantitative or Qualitative)	0 PHC centers	26 PHC centers in 6 rayons		2 OHDs and 68 facilities in 7 rayons
Date achieved	19-Aug-2009	31-Dec-2010		31-Dec-2012
Comments (incl. % achievement)	***Exceeded.*** Source: ISR No.14 dated December 10, 2012; PIU data.			
Indicator 32:	D: Phase 1 of Action Plan of the Health Sector Fiduciary Capacity Assessment Report implemented *(included under AF1)*			
Value quantitative or Qualitative)	Fiduciary (Procurement) Unit created	Phase 1 fully implemented		80% of Phase 1 Action Plan implemented
Date achieved	22-May-2009	31-Dec-2010		31-Dec-2010
Comments (incl. % achievement)	***Partially achieved.*** Training of rayon accountants in 1C was not implemented. Source: PIU/MOH Final Completion Report for 2006-2012, Vol. II, Annex 10; ISR No.14 dated December 10, 2012.			
Indicator 33:	Number of hospitals in project-supported rayons that have introduced BBP *(included under AF2)*			
Value quantitative or Qualitative)	Total 6 hospitals: Spitamen - 3 Sarband - 2 Nurek - 1	Soghd oblast: all hospitals in 18 rayons, Khatlon oblast: all hospitals in 2 rayons		Total 6 hospitals: Spitamen - 3 Sarband - 2 Nurek - 1
Date achieved	01-Jun-2009	31-Dec-2012		31-Dec-2012
Comments (incl. % achievement)	***Not achieved.*** Expansion of the BPMCS to other rayons was temporarily put on hold based on the Governmental Decree No.579 “On the approval of the BPMCS for 2012-2013” dated December 3, 2011. Source: ISR No.14 dated December 10, 2012.			
Indicator 34:	Health personnel receiving training *(Core Sector Indicator, introduced in July 2009)*			
Value quantitative or Qualitative)	0	240 doctors, 616 nurses (incl. AF1)	FM training for 30 doctors and 222 nurses from 3 additional	FM training for 290 doctors and 833 nurses (incl. 30 doctors and 198 nurses from 3

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
			rayons; CME training for 280 doctors and 857 nurses from 9 rayons	rayons under AF2); CME training for 1,058 retrained health staff
Date achieved	15-Dec-2005	31-Dec-2010	31-Dec-2012	31-Dec-2012
Comments (incl. % achievement)	***Achieved.*** Exceeded on FM training (1,123 vs. 1,108); partially achieved on CME training (1,058 vs. 1,137). Source: PIU/MOH Final Completion Report for 2006-2012, Vol. II, Annex 10.			
Indicator 35:	Number of facilities constructed, renovated and equipped *(Core Sector Indicator, introduced in July 2009)*			
Value quantitative or Qualitative)	0	53 (incl. AF1)	7 additional rural PHC facilities	68 buildings, incl. 5 PHC facilities under AF2
Date achieved	15-Dec-2005	31-Dec-2010	31-Dec-2012	31-Dec-2012
Comments (incl. % achievement)	***Exceeded.*** A total of 68 buildings improved vs. cumulative target value of 60 (50, 3, and 7 under CBHP, AF1, and AF2, respectively). Source: PIU/MOH Final Completion Report for 2006-2012, Vol. I and II.			
Indicator 36:	Pregnant women receiving antenatal care during a visit to a health provider *(Core Sector Indicator, introduced in July 2009)*			
Value quantitative or Qualitative)	0	4,229		4,229
Date achieved	15-Dec-2005	31-Dec-2010		31-Dec-2010
Comments (incl. % achievement)	***Achieved.*** Source: ISR No.14 dated December 10, 2012.			

G. Ratings of Project Performance in ISRs

No.	Date ISR Archived	DO	IP	Actual Disbursements (USD millions)[21]
1	07/07/2006	Satisfactory	Satisfactory	0.64
2	10/06/2006	Satisfactory	Satisfactory	1.11
3	04/05/2007	Satisfactory	Satisfactory	1.95
4	02/05/2008	Satisfactory	Satisfactory	3.88

[21] These amounts include only IDA grant funds and do not include SIDA and SDC co-financing and the Global Food Price Crisis Response TF grant.

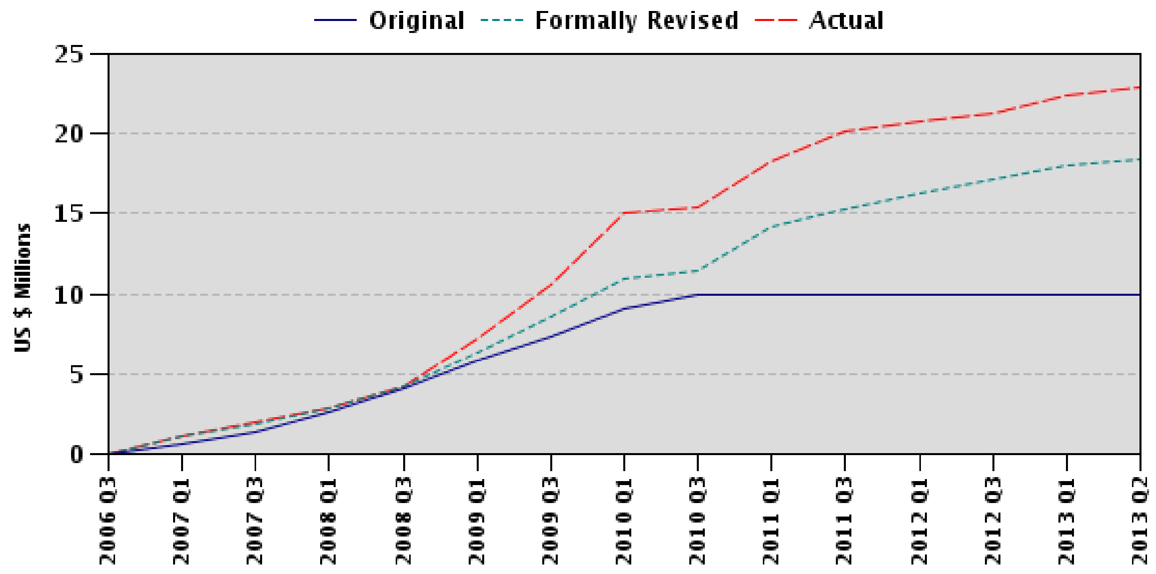
No.	Date ISR Archived	DO	IP	Actual Disbursements (USD millions)[21]
5	11/17/2008	Satisfactory	Satisfactory	7.63
6	06/11/2009	Satisfactory	Highly Satisfactory	8.98
7	07/31/2009	Satisfactory	Highly Satisfactory	9.15
8	11/16/2009	Satisfactory	Highly Satisfactory	10.99
9	05/14/2010	Satisfactory	Highly Satisfactory	11.65
10	12/22/2010	Moderately Satisfactory	Satisfactory	15.56
11	07/05/2011	Satisfactory	Satisfactory	16.52
12	01/23/2012	Satisfactory	Satisfactory	17.10
13	07/16/2012	Satisfactory	Moderately Satisfactory	17.81
14	12/10/2012	Moderately Satisfactory	Satisfactory	18.91

H. Restructuring (if any)

Restructuring Date(s)	Board Approved PDO Change	ISR Ratings at Restructuring		Amount Disbursed at Restructuring in USD millions[22]	Reason for Restructuring & Key Changes Made
		DO	IP		
04/30/2009	N	S	HS	8.61	This Level I restructuring (i) upgraded the environmental safeguards category from C to B due to the construction of 11 PHC centers on new sites, and (ii) extended the closing date by 9 months to coincide with the closing date of the AF1.
08/30/2010	N	S	HS	13.92	This Level II restructuring involved a reallocation of funds in order to reflect funding needs by category more accurately and to utilize project savings.

[22] These amounts include only IDA grant funds and do not include SIDA and SDC co-financing and the Global Food Price Crisis Response TF grant.

I. Disbursement Profile



1. Project Context, Development Objectives and Design

1.1 Context at Appraisal

1. ***Country and Sector Background.*** In 2002-2005, Tajikistan's first Poverty Reduction Strategy (PRS) reflected the importance the government's reform program placed on improving health sector performance to advance overall health status and achieve health outcomes outlined by the Millennium Development Goals (MDGs). After the dissolution of the Soviet system, Tajikistan experienced years of civil war (1993-97), which resulted in severe economic decline, leaving Tajikistan one of the poorest countries in the world, with a social infrastructure, including the health system, in a near-state of collapse. The breakdown of infrastructure and health services, particularly in rural areas, led to resurgence in previously well managed communicable diseases: malaria has become endemic in regions bordering Afghanistan and periodic outbreaks of typhoid fever and measles attest to inadequacies of both the water supply system and public health programs. Nearly one third of children suffered from chronic malnutrition and morbidity and mortality rates of the main non-communicable diseases (NCD), such as hypertension and ischemic heart disease, had increased as well. As a consequence, Tajikistan had the poorest health outcomes among CIS countries and its epidemiological profile resembled that of the lowest income countries in the world.[23]

2. Between 1999 and 2003, Tajikistan experienced a return to peace and stability, which facilitated modest gains in wellbeing. Health spending was just under $12 per capita in 2003, placing Tajikistan among the lowest spenders on health in the world. At this level of spending the country had barely enough resources to cover the recurrent costs of the most basic health services.[24] The public budget contributed just $2 per capita or 16 percent of the total. The government budget for the health sector represented less than one percent of GDP in 2003. The health sector was characterized by poor health outcomes, misallocation of staff and other resources, inefficient production of care, and hospital overcapacities. The latter was aggravated by the input-based provider payment system, as hospital beds were unequally distributed between urban and rural areas, resulting in inequity of access. The lack of pooling of health funds had contributed to geographic disparities and underfunding, which hampered the efficient use of resources and posed a threat to access to care for low-income groups, particularly in rural areas. Financial barriers were cited most often as a reason for not accessing health services, coupled with physical barriers being most acute in the remote mountainous regions, especially during the winter season. Years of under-financing left much of the existing infrastructure in a state of disrepair and a large numbers of qualified health workers were lost to migration.

3. Thus, the public health situation in Tajikistan was bleak and required an immediate solution that would meet the short-term, urgent basic health care needs of the population. The Government of Tajikistan (GOT) recognized that an immediate response would need to be: (i) limited to the state budget; (ii) minimal in scope, focusing solely on

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[23] Republic of Tajikistan. Health Sector Note (Report No.29858-TJ), June 30, 2005.
[24] The Commission on Macroeconomics and Health (2001) estimated that a minimal health service package addressing the most common communicable diseases would cost around $34 in the least developed countries.

priorities such as basic maternal and child health (MCH) services and the prevention and control of TB, HIV/AIDS, and malaria.

4. At the same time, GOT developed a medium-term strategy that focused on: (i) health financing reforms aiming at mobilizing resources to finance essential health service; (ii) restructuring of the health delivery system to expand the primary health care (PHC) network based on the family medicine (FM) model and strengthening the public health functions; (iii) ensuring more effective service delivery for the poor through better integration of public health, personal health care, and community health approaches; and (iv) improving transparency and accountability at all levels by promoting participatory monitoring and evaluation (M&E).[25]

5. ***Country Assistance Strategy and Rationale for Bank Assistance***. The government's reform objectives were shared by the Bank's strategy for Tajikistan, which aimed to help "preserve and enhance the quality of health and education services".[26] The preceding Bank-financed Primary Health Care Project (PHCP), implemented in 2000-2005, introduced a model of health care delivery based on primary care and enabled the construction of 25 rural health facilities. The rationale for the Bank's further involvement in the health sector was grounded in: (i) the Ministry of Health's (MOH) increasing ability to manage the complex transition to sustainable development, its open recognition of unresolved sector issues, commitment to complex policy and financing reforms; and (ii) the Bank's strong relationship with MOH, ability to continue coalition-building with other donors, and its planned support to management and payment reforms in PHC through a policy-based operation.

1.2 Original Project Development Objectives (PDO) and Key Indicators

6. The PDOs were to: (i) increase access to, utilization of, and patient satisfaction with health services in project-supported areas; and (ii) build capacity and efficiency at the national, oblast and rayon levels in administering a basic package of health benefits and introducing financing reforms in PHC.[27]

7. The PDOs were to be achieved through:

(a) Strengthening coherence and coordination in policymaking, policy analysis, and the management of donor support by MOH;

(b) The support to the implementation of per capita financing for PHC and the Basic Program of Medical Care Services (BPMCS); and

(c) The renewal of the PHC infrastructure in 2-4 rayons in Soghd and Khatlon oblasts and complementary measures to improve service delivery and outreach.

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[25] Republic of Tajikistan. Health Sector Note (Report No.29858-TJ), June 30, 2005.
[26] Country Partnership Strategy for the Republic of Tajikistan for the period FY06-09 (Report No.32294-TJ), October 3, 2005.
[27] The wording of the PDO was the same in the main text and Annex 3 of the Project Appraisal Document (PAD, Report No. 34080-TJ). Although it was slightly different in the Financing Agreement, the difference in wording did not alter the substance.

8. The achievement of the PDO was to be measured by the following outcome indicators as identified in the main text of the PAD.[28]

(a) Decrease in percentage of households in project-supported areas who don't seek health care when necessary because they cannot afford it;

(b) Decrease in share of health costs as a percentage of total household expenditure in project areas;

(c) More equitable distribution of the health budget through implementation of per capita financing in PHC and case-based payment for hospitals;

(d) Improvement in PHC infrastructure, services, and patient satisfaction in project areas.

1.3 Revised PDO and Key Indicators

9. The PDOs were not revised.

1.4 Main Beneficiaries

10. **Project investments were intended to benefit the following:**

a) MOH, oblast health departments (OHD) and rayon health and finance departments of the 41 rayons of the Soghd and Khatlon oblasts through strengthened capacity, coherence and coordination as well as through strengthened PHC and hospital management and financing, and capacity to implement the BPMCS;

b) Front-line PHC workers in project-covered rayons through re-training under an approved FM training course;

c) The populations of the Soghd and Khatlon oblasts (3.2 million people at appraisal) were to benefit from improved access to and utilization of PHC services in rural areas through rehabilitated PHC infrastructure and improved quality of basic services. Intended benefits also included improved financial protection through the expansion of the BPMCS, exemption of poor and vulnerable households from co-payments, and reduction of informal payments. Indirect benefits included reduced travel time for patients, and improved social welfare and productivity of the population. The communities were to be empowered to address their priority health needs through institutionalized community structures, capacity for prioritization and micro-planning, grant financing, and close dialogue with community nurses and feldshers.

1.5 Original Components

11. The Project included the following four components:

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[28] Note that the Supplemental Letter No.2 included only the first two of these four PDO indicators.

12. ***Component A. Strengthening Policy, Planning, and Donor Coordination in the Ministry of Health*** *(US$1.46 million or 10 percent of total project baseline cost)* would support four streams of activity:

13. *A1. Policy Formulation and Analysis sub-component* included the establishment of a Health Policy Analysis Unit (HPAU) under the MOH's Department for Planning, Coordination and Implementation of Health Reforms to perform analytical functions such as: (i) monitoring and evaluation of health reforms through client satisfaction surveys, public expenditure tracking (PETS) surveys, and out-of-pocket payment surveys; and (ii) provision of evidence-based advice on policy development in response to MOH needs through the preparation of National Health Accounts (NHA), functional and legislative reviews of the health sector, and a basic sector Medium-Term Budget Framework (MTBF).

14. *A2. Strategic and Operational Planning sub-component* included the development of a comprehensive sector strategy based on sub-sectoral strategies with the aim of improving the coherence of sector policies and donor-financed activities.

15. *A3. Donor Coordination sub-component* would help MOH improve donor coordination through biannual sector review conferences aiming at collective policy analysis, communication of policy objectives, joint planning, and, most importantly, improving coordination between the government and international donors.

16. *A4. Public Relations and Communication sub-component* included the strengthening of the public relations capacity of the MOH by supporting: (i) the operation of the earlier established Public Relations (PR) unit; (ii) ongoing PR activities and communication programs connected with the MOH's overall reform program; and (iii) the development of a communication strategy for the MOH.

17. ***Component B. Implementing Organizational and Financing Reforms in the Health Sector*** *(US$4.29 million or 29 percent of total project baseline cost)* included three subcomponents:

18. *B1. Strengthening PHC Management and Financing sub-component* included: (i) management training, furniture, and computers to build the capacity of the newly-formed rayon PHC Departments in 41 rayons of the Soghd and Khatlon oblasts to manage the network of facilities in their charge; (ii) development of a basic rayon-level PHC management information system (MIS) for utilization tracking and basic disease surveillance; (iii) an outreach vehicle for each rayon department for supervisory visits to subordinate clinics in the rayon; and (iv) local TA for the OHDs to act as "PHC coaches" following the Tendler and Freedheim model of Ceara, Brazil.[29] These project activities were to build on and be complemented by a number of measures under the Policy-based Credit designed to strengthen PHC management and financing and enable the effective implementation of per capita-based budgeting for PHC including: (i) administrative separation of PHC from hospitals at the rayon level; (ii) a treasury account for PHC at the rayon level, separate from that of the Central Rayon Hospital (CRH); (iii) collection of all PHC facilities—and their per capita based budgets—under the authority of a rayon-level

[29] Tendler, Judith, and Sara Freedheim. 1994. "Trust in a Rent Seeking World: Health and Government Transformed in Northeastern Brazil." *World Development* 22(2):1771–91.

PHC department and manager in a network model; and (iv) adoption of per capita budgeting for calculating and distributing rayon PHC budgets.

19. *B2. Strengthening Hospital Management and Implementing the Basic Program of Medical Care Services sub-component* included **at the hospital level**: (i) provision of furniture, computer, and basic software for hospital accounting departments and training for their new role as an active collector of fee revenues and case-based payments; (ii) adaptation of the basic HMIS software package to serve billing and receiving functions; and (iii) development of business plans that link revenue sources for the hospital with their expected use. **At the oblast level**, (i) the introduction of a purchasing function in the pilot OHDs by providing them with management training, computers as well as a server and *de novo* developed software to receive and process hospitals' payment claims; (ii) local IT consultants to maintain servers and provide IT support; (iii) periodic and in-service training of oblast staff in conjunction with counterparts in the MOH; and (iv) local and international TA for continuous development and dissemination of information on fees and patients' rights, including the establishment of an oblast-level hotline for complaints.

20. *B3. Strengthening MOH Oversight of Organizational and Financial Reforms sub-component* included the strengthening of hospital policy development in the Economic and Financial Planning unit of the MOH by: (i) refining output-based budget formulation methods, initially focusing on the refinement of the PHC per capita financing and on costing and fine-tuning the BPMCS; (ii) applying an output-based budget formulation to the development of the MTBF and the annual budget process; and (iii) monitoring health financing indicators with the objective of developing baseline NHA.

21. ***Component C. Strengthening Primary Health Care in Selected Rayons*** *(US$8.06 million or 55 percent of total project baseline cost)* originally included the following three subcomponents:

22. *C1. Strengthening the PHC Infrastructure sub-component* envisaged (i) the rehabilitation or replacement of PHC facilities in 2-4 rayons in Sughd and Khatlon oblasts selected based on a PHC rationalization plan; (ii) furniture, equipment, and radio-communication equipment for the facilities; (iii) and an engineer/architect and field coordinators for supervision by the Project Implementation Unit (PIU). The rehabilitation/construction works were to be based on revised building standards and norms and standard design packages for rural health facilities.

23. *C2. Strengthening PHC Services and Outreach sub-component* (financed in parallel by the Swedish International Development Agency (SIDA)) was designed to support (i) a technically-guided dialogue process between health workers and communities to identify service bottlenecks and plan solutions, which would progressively be supported by staff from the rayon PHC department in order to build supervision capacity on their part; and (ii) a small grants program to address the issues in question, explicitly considering issues of child and maternal mortality and access to pharmaceuticals. Examples of such activities included *inter alia* the following: establishing or using an existing institutional structure for consultation and action on health issues at the village level; designing a program of targeted interventions for vulnerable groups and priority health issues; developing proposals for remedial actions that can be financed with small grants of less than US$500, etc.

24. *C3. Strengthening PHC Training sub-component* included re-training of, at a minimum, all PHC workers in project rayons under an approved family medicine training scheme.

25. ***Component D. Project Coordination and Capacity Building for Implementation*** *(USS0.62 million or 4 percent of total project baseline cost)* [30] included project management by the PIU to support the MOH in the administration and coordination of the project. Field supervisors were to be hired as local consultants to oversee civil works. As opposed to the previous project, component specialists in this project were to be co-located with their counterparts in the MOH. The PIU was also, over time, to be located within the Ministry, both to ensure close coordination and to facilitate capacity development for project implementation and fiduciary functions in the MOH itself.

1.6 Revised Components

26. See section 1.7 on changes to the components in terms of their scope and scale.

1.7 Other significant changes

27. Changes to the project included: three occasions of additional financing (AF), two cases of restructuring, reallocations of funds on two occasions, one extension of closing date, and a cancellation of funds.

Additional Financing

28. The US$4 million of AF from the Global Food Crisis Response Trust Fund (GFPCR TF092349) was an emergency response to the combined impact of the harsh winter of 2007-2008 coupled with power shortages and high energy prices, and a resulting severe financial and food crisis.[31] It entailed the addition of 3 subcomponents to Component C of the CBHP and 7 new Intermediate Outcome (IO) indicators to the Results Framework (RF) to monitor the progress under those subcomponents.[32]

29. The US$5 million equivalent AF1 (IDA-H4610; hereinafter, AF1)[33] supported: (i) the financing gap under the CBHP related to the overall price inflation due to the financial crisis; and (ii) the scaling up of the CBHP activities, as detailed in Annex 10. The RF was updated with 7 new IO indicators specific to the AF1-supported activities, two new PDO indicators, and a modification of one original PDO indicator.

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[30] The Project Preparation Advance of US$300,000 accounted for the remaining 2 percent of the total baseline cost.
[31] Approved by the Board on June 13, 2008; the Grant Agreement was signed and became effective on July 17, 2008, with the closing date of March 31, 2010
[32] The subcomponents supported: C3) nutritional supplements and nutrition education to pregnant and lactating women; C4) growth monitoring equipment for primary health care centers; and C5) food packages for undernourished women at PHC centers. The closing date under the Grant Agreement dated July 17, 2008 was March 31, 2010.
[33] Approved by the Board on April 30, 2009; the Financing Agreement was signed on May 22, 2009 and declared effective on August 11, 2009, with the closing date of December 31, 2010.

30. The US$3 million equivalent AF2 (IDA-H5860; hereinafter, AF2)[34] scaled up the CBHP and AF1 activities, as detailed in Annex 10.

Reallocation

31. The first reallocation of the original Grant proceeds in the amount of SDR 116,000 (US$180,000 equivalent) from “Unallocated” to “Operating Costs” category[35] was due to: (i) initially underestimated operating costs, which were exacerbated by inflation in overall costs in conjunction with the then ongoing economic crisis; and (ii) increased burden on operational costs related to the PIU’s parallel administration of the GFPCR AF and preparation of the new Health Sector Strategy Support Project.

32. The second reallocation[36] permitted the unallocated SDR 404,000 and Project Preparation Advance (PPA) savings of SDR 42,627 to be reallocated to the “Works, Goods and Consultants’ Services” and “Operational Costs” categories in order to reflect funding needs by category more accurately and to utilize project savings in the PPA category (see Annex 1, Table d).

Restructuring

33. The first (Level I) restructuring for the undisbursed portion of the original project included: (i) an upgrade of the Environmental Category from C to B (see Section 2.4); and (ii) an extension of the CBHP closing date from March 31, 2010 to December 31, 2010 to align it with the closing date of the AF1 to allow for the preparation of the Implementation Completion and Results (ICR) Report for both.[37]

34. The second (Level II) restructuring involved only the reallocation of funds as detailed above and in Annex 1, Table d.

Cancellation

35. SDR548 from the AF1 was cancelled as of April 30, 2011 as undisbursed balance at closing, which originated due to the exchange rate fluctuations and ensuing currency gain, with the disbursement under the AF1 at closing amounting to US$5.19 million equivalent.

2. Key Factors Affecting Implementation and Outcomes

2.1 Project Preparation, Design and Quality at Entry

36. The ICR team rates Project Preparation, Design and Quality at Entry as ***Moderately Satisfactory*** on the basis of the following factors:

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[34] Approved by the Board on July 1, 2010; the Financing Agreement was signed on August 5, 2010 and declared effective on November 3, 2010, with the closing date of December 31, 2012.
[35] Processed on October 30, 2008 through the Country Director’s approval in response to the request from the Ministry of Finance dated October 16, 2008.
[36] Processed on August 30, 2010 through the Country Director’s approval in response to the request from the Ministry of Finance dated August 6, 2010.
[37] Processed on April 30, 2009 along with the AF1 through the Board approval following the Bank-wide HNP portfolio review.

37. ***Project Preparation.*** The project was prepared within a period of 10 months and under tight budget constraints: a sizeable portion of the budget was spent on the preparation and dissemination of the Tajikistan Health Sector Note, Report No.29858-TJ.[38] Project preparation was supported by a Japanese Trust Fund[39] for: (i) baseline surveys and stakeholder assessment; (ii) rationalization and investment plans for rayon health systems in selected rayons; (iii) action plan for community-based health promotion and public health programs; (iv) operationalization of community health grant program; (v) Project Implementation Plan and Operational Manual; (vi) Technical Norm; and (vii) Standard Design Packages.

38. Apart from the PHRD Grant, the GOT requested a PPA[40] in order to: (i) implement additional activities for the CBHP preparation—such as the development of a PHC rationalization plan in two oblasts and a training plan to support community-based health promotion, public health programs, and the small grants program; and (ii) provide operational costs and capacity building for the implementation of the PHRD Grant and during the estimated 9-month period between the closing of the PHCP and effectiveness of the CBHP.

39. The entire project was financed by a total of 6 grants. The original IDA grant of US$10 million equivalent, in the form of Specific Investment Lending (SIL), was co-financed by two grants from SIDA and SDC (US$6 million and US$1.2 million equivalent, respectively), with SDC funds earmarked to subcomponents A3 and C3. The project also received three IDA grants as AF in 2008, 2009, and 2010 (US$4 million, US$5 million equivalent, and US$3 million equivalent, respectively). The first five grants were fully disbursed at closing in 2010, with only SDR548 from AF1 cancelled as undisbursed currency gain (see Section 1.7).

40. ***Quality at Entry.*** The project's quality at entry was ***Moderately Satisfactory*** based on the following:

41. ***Soundness of background analysis.*** An extensive analysis of the issues affecting access to, utilization, and quality of health care services, as well as the overall performance of the health system was summarized in the Tajikistan Health Sector Note. The report also provided policy recommendations for short- and medium-to-long-term strategies to address both immediate needs and systemic reforms. The preparation also benefitted from analytical work identifying macro issues and implications for the project design, such as Tajikistan Poverty Assessments, 2000, 2004 and Public Expenditure and Institutional Review, 2004.

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[38] Minutes for the Concept Review Package for Tajikistan Community and Basic Health Project dated February 11, 2005. Also, refer to Annex 4.

[39] PHRD Grant (TF053126) was signed on April 5, 2004, with the original closing date of December 6, 2005 which was extended twice until March 22, 2006 or CBHP Grant Effectiveness, whichever would come first. The Grant (US$500,000) was nearly fully disbursed and closed on May 25, 2006.

[40] Letter from the Ministry of Finance dated November 30, 2004. The PPA (IDA-Q4680) was signed on March 25, 2005, with the original closing date of June 30, 2005, which was extended once until March 31, 2006 due to the change in the original timetable for the CBHP preparation. A reallocation of US$35,000 was processed on January 26, 2006 from Category 2 (Consultant Services) to Category 4 (Operating Costs). Of the total amount of US$300,000, US$240,275 was disbursed; the remaining amount was reallocated to other categories (see Annex 1, Table d).

42. ***Quality Enhancement Review (QER).*** A QER was conducted prior to project appraisal. The project was found to be soundly designed with an adequate balance of ambitiousness and risk. It was also considered to be appropriate to the context, with the recognition that implementation would be challenging given the institutional reforms to be supported. The need for close attention to coordination both within the government, between the levels of government, and with other donors was emphasized. Specification of M&E arrangements in greater detail was also recommended. Most recommendations by the QER were taken into account and reflected in the revised PAD.

43. ***Assessment of Project Design.*** The overall objective of the project was consistent with the identified sector issues, PRS, National Development Strategy (NDS), the Concept of Health Reform in Tajikistan for 2002-2010, and the Bank's country strategy.[41] The project components, as designed, did comprehensively address the key needs of the country's health sector at all levels, including the focus on the renewal of PHC infrastructure combined with improvements in service delivery, community outreach, and health worker training. The project built on prior rigorous analytical work and lessons from the preceding Bank-financed PHCP. It envisaged a phased approach to reforms and the "learning-by-doing" modality for the MOH's capacity building and coordination. The design also safeguarded policy reforms under the ongoing Bank budget support through a Letter of Development Policy (LDP) and leveraged the complementarities with other development partners' (DP) previous and ongoing work, e.g., the ZdravPlus-developed hospital MIS. Although stakeholder views regarding the level of the project's ambitiousness varied, all unanimously acknowledged the project to be the most comprehensive health sector operation in Tajikistan to date.

44. At the same time, the design was challenging due to the lack of institutional capacity; multitude of partners and stakeholders involved; variety of funding sources and arrangements; and the intertwinement of the project activities with each other and their dependence on policy measures by the GOT. In fact, the retention of the experienced PHCP PIU for implementation of the CBHP and management of the civil works was designed to compensate for the initial capacity constraints. However, the expectation for timely and consistent government actions for the implementation of the project as planned proved optimistic, especially given the unforeseen global economic crisis impacts.

45. Several project design alternatives were considered.[42] The option of a policy-based operation was rejected in view of Tajikistan's substantial investment needs. An immediate move to a SWAp arrangement was also rejected at appraisal because of the overall weak administrative capacity of the MOH, as well as a lack of donor coordination and the absence of a widely agreed upon health sector strategy.[43] An exclusive focus on service delivery at the grassroots level was rejected for many reasons: (i) failure of the many existing targeted grassroots interventions to collectively translate into improved performance of the *public* health sector; (ii) incentive problems and structural failings in the public delivery system itself; (iii) the inability of disease-focused interventions to

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[41] Country Partnership Strategy for the Republic of Tajikistan for the period FY06-09 (Report No.32294-TJ), October 3, 2005.

[42] Project Appraisal Document for Tajikistan Community and Basic Health Project (Report No: 34080-TJ), November 23, 2005.

[43] This was fully consistent with the then new Country Partnership Strategy for FY06-09, in which a follow-on project to be implemented through a SWAp arrangement was included for 2009.

address the significant inequalities in the burden of health financing and out-of-pocket payments; and (iv) the need for a combination of technical expertise and investments to support the GOT's ambitious structural reform program, an area in which the Bank has considerable comparative advantage and, thus, demand.

46. ***Lessons learned from previous Bank-financed projects.*** The project design incorporated several key lessons drawn from the implementation of other health reform projects in the ECA Region, which included the following:

- Clear recognition of the political and technical complexity of rationalizing health facilities, especially hospitals, *without* changes in the provider payment system in a post-conflict country with high poverty, very weak infrastructure, and geographical challenges.
- The complexity of supervising remote civil works to be completed on time and at a reasonable cost and, thus, the importance of outreach and closer coordination with local communities to build ownership and support as well as very close planning and supervision of the process at both the national and local levels.
- The need for policy-based lending to complement project activities and support institutional reforms, and "anchoring" activities in the country's policy or program context to ensure sustainability.

47. ***Risk Assessment.*** A comprehensive list of risks to PDOs and component results was included in the PAD. The mitigation measures were adequately identified for most of the risks. Still, some risks were either unforeseen or the envisaged mitigation measures turned out to be insufficiently adequate or beyond the project's control. Thus, the potentially insufficient allocations to the health sector and implementation feasibility and sequencing of key blocks of the Health Sector Financing Strategy (HSFS) 2005-2015[44] were underestimated, as were some critical risks for the implementation of Component B. For example, the only risk identified for Component B was the failure of BPMCS to reduce informal payments because of failure to implement payment reforms—mitigation measures were defined as the provision of management training for BPMCS implementation, PR strategy implementation, and the creation of opportunities for redress. Moreover, the feasibility of scaling up hospital case-based payment and PHC financing reforms in the context of persisting input-based, fragmented financing system were not fully evaluated at the design stage. The materialized risks led *inter alia* to the financial inadequacy of the BBP, introduction of hospital fee-for-services system, and a much slower pace of financing reforms than intended.

48. ***Adequacy of participatory processes.*** The preparation benefitted from close collaboration with a wide range of DPs and projects involved in the Tajikistan health sector, including SIDA, the Swiss Development Cooperation (SDC), the United States Agency for International Development (USAID)-funded ZdravPlus Project (subsequently, Quality Health Care Project-QHCP), SDC-funded Project Sino, the World Health Organization (WHO), Asian Development Bank (ADB), UN Emergency Fund for

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[44] The Strategy included the following key blocks: establishment of a single payer, pooling of public funds at the oblast level, development and implementation of new provider payment methods, increased public financing, output-based budget formulation, and reorganization of health care delivery system.

Children (UNICEF), Aga Khan Foundation, and a number of local NGOs.[45] The collaboration ranged from direct participation in the project design to close coordination in areas of common interest, including the use of management training curricula developed by ZdravPlus Project, and HMIS work done by ADB, ZdravPlus, WHO, and Project Sino.

49. ***Adequacy of government commitment:*** (i) in accordance with the PRS, the GOT adopted in May 2005 the HSFS for 2005-2015, which provided an important framework for the implementation of health financing reforms in the medium term; (ii) the MOH confirmed its commitment to the key structural, institutional and health financing reforms supported by the project in the LDP;[46] (iii) key stakeholders were involved in project preparation from the outset, such as the National Board on Health under the Prime-Minister Office and the Aid Coordination Unit in the President's Administration; and (iv) the well-established and experienced PIU from the previous Bank-financed PHC project was retained for the implementation of the CBHP.

2.2 Implementation

50. The project succeeded in delivering nearly all of the outputs under the four components and the Food Price Crisis AF (refer to Annex 2). The project was rated Satisfactory throughout, in terms of both Development Objective (DO) and Implementation Progress (IP), with DO downgraded to Moderately Satisfactory only twice. The first was in December 2010 due to the lack of clear and consistent data on progress towards the PDO, and the second in December 2012 as an overall DO rating for the project because some PDO indicators were only partially achieved. IP was consistently rated Highly Satisfactory from June 2009 to May 2010, and Moderately Satisfactory only once in May 2012 due to a disbursement delay. The project was never considered at risk during its implementation period and performed well both at the central, oblast, and rayon levels despite challenges presented by a complex policy environment and the adverse impacts of the economic crisis.

Positive factors in implementation

51. ***Strong GOT ownership during the early implementation period*** was reflected in a number of consistent and decisive GOT actions, including, *inter alia*, the adoption in February 2006 of an Action Plan for the implementation of the HSFS; and the establishment of 19 working groups early in the process for the development of the envisaged sub-strategies, including a working group to develop a communication strategy chaired by an MOH deputy minister.

52. ***The Bank-supported programmatic development policy grants (PDPG)*** reinforced project investments in infrastructure, capacity building, and in establishing systems and processes; most importantly, they highlighted the sector needs to the GOT. Thus, the legal framework for the strengthening of PHC management and financing—as contemplated in the PAD—was adopted under PDPG-1.[47] Likewise, the allocation of a

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[45] Project Appraisal Document for Tajikistan Community and Basic Health Project (Report No: 34080-TJ), November 23, 2005.
[46] Letter of Development Policy from the Ministry of Health dated September 27, 2005
[47] The Joint Order of the Ministry of Health and Ministry of Finance No.609 dated December 25, 2006.

greater share of health sector wage bill increases to PHC workers' wages was implemented between 2006 and 2008 under PDPG1-3. These policy actions helped shift financial and human resource allocations towards the strengthened, PHC-centered health care delivery model.

53. ***The Bank's continuous focus on sustainability of investments and flexibility in adjusting the project scope based on emerging issues and needs.*** For example, the Food Price Crisis AF of 2008 addressed the impact of sharply rising food prices on the nutritional status of pregnant and breastfeeding women and children in the Soghd and Khatlon oblasts. Likewise, the increase in construction costs by 87% between 2006 and 2008 due to hikes in wages, operational costs, and construction material prices necessitated the provision of the AF1 in 2009 to enable the completion of the originally planned activities and maximize the project's development impact.[48]

54. ***Effective administration of the project by the PIU*** was acknowledged in all the aide memoires and consistently rated Satisfactory or Highly Satisfactory. Despite the replacement of the PIU Director in early 2011, the PIU's accumulated project management experience secured efficient and timely completion of the project activities that were within its control.

Less effective factors influencing implementation

55. ***Overall fiscal limitations resulted in considerable, chronic underfunding of the health sector and impeded implementation of BPMCS and PHC financing reforms.*** During project implementation, public funding for the health sector increased from 1.3% of GDP in 2006 to 2.0% in 2011,[49] with most of the funding supplementing health workers' salaries. While additional public financing for non-salary expenditures was considered critical for moving towards full capitation in PHC and effective financing of the BPMCS, its lack—aggravated by the economic crisis—proved detrimental to increasing access to health services for the poorest. For example, the national average for the percentage of households who did not seek health care when necessary because they could not afford it rose from 26.7% in 2003 to 53% in 2009.

56. ***Considerable capacity constraints in the sector*** both at the central level and among oblast, rayon and facility administrators. For example, the MOH's nascent institutional capacity in health policy, planning and management was heavily restrained initially by the lack of a coherent national health strategy unifying the key stakeholders around a shared sector vision and objectives. This limited the MOH's ability to avoid fragmentation among DPs and to improve MOF's understanding of the complex functioning of the health sector in order to gain its support to a consistent and shared reform path.[50]

57. ***Disagreement on health financing reforms between the MOH and MOF*** after 2009 proved to be the stumbling block for scaling up the reforms. The MOF was concerned about: (i) the lack of a comprehensive, clear vision and implementation capacity for the reforms on the MOH side, including the clarity on how the reforms would

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[48] Project Paper for the first Additional Financing (Report No.47561-TJ), April 7, 2009.
[49] Data from the Ministry of Health of the Republic of Tajikistan.
[50] This view was shared by the Vertical Functional Review of the Ministry of Health and in most of the interviews the ICR team conducted.

lead to improved quality and efficiency of health services;[51] and (ii) the MOH's limited public finance management capacity to prevent potential financial misuses in the sector while moving away from the traditional line-item budgeting. Thus, in the absence of progress in pooling of funds at the oblast level and further scaling up of case-based payment system, the project activities focused mainly on development of hospital business plans, health staff capacity building, and information campaigns on the population's rights under the BPMCS.

58. While policy dialogue on financing and organizational reform issues had increasingly become a multi-donor affair,[52], this uncertainty in policy environment called for a consistent dialogue and capacity building effort from DPs, involving not only the MOH but, importantly, also the MOF. Regrettably, the lack of shared approach to substantive aspects of reforms (PHC capitation, funds pooling, and FM and CME training) among DPs themselves at different stages of project implementation fell short of building a shared vision and consensus within the GOT. This was exacerbated by the lack of a convening power to lead the policy dialogue on implementation of structural reforms with the GOT at the highest level (which most of the interviewed stakeholders saw as the World Bank's mandate). The Bank's implementation-focused engagement in this area remained somewhat insufficient, with PDPGs focusing on adoption of policy measures, and CBHP mostly on capacity building activities and service delivery. All these factors collectively resulted in the absence of a critical mass supporting health financing reforms and made them nearly an impossible undertaking.

2.3 Monitoring and Evaluation (M&E) Design, Implementation and Utilization
Rating: ***Modest***

59. **M&E Design is rated *Modest*.** The design of the M&E system had the following weaknesses: (i) an extensive number of PDO and IO indicators (14 and 20, respectively, listed collectively in the PAD and Supplemental Letter No.2);[53] (ii) missing baseline and target values for half of the proposed PDO indicators, especially those measuring improvements in service delivery and patient satisfaction; (iii) reliance of the two main PDO indicators on the Tajikistan Living Standards Survey (TLSS) conducted outside of the project scope, with their baseline and target values specified for the national level while the project investments only covered selected rayons in two oblasts; (iv) complexity and process orientation (number of rayons covered or staff trained) of some indicators, including for PDO; (v) inclusion of indicators that did not directly and solely reflect the project activities, e.g., PDO indicator "More equitable distribution of the health budget through implementation of per capita financing in PHC and case-based payment for hospitals" although hospital payment reform was supported by ZdravPlus. For these reasons, the project monitoring presented challenges throughout the implementation period, especially due to the lack of updated, accurate, and comparable data for the two

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[51] This issue was also identified by the Vertical Functional Review of the Ministry of Health commissioned in 2009 by the Executive Office of the President of the Republic of Tajikistan.

[52] Country Partnership Strategy for the Republic of Tajikistan for the period FY06-09 (Report No.32294-TJ), October 3, 2005.

[53] The Supplemental Letter No.2 did not include all the indicators listed in the PAD, and the wording of some indicators differed between the two documents. The reasons for using the indicators from the "Arrangements for results monitoring" table of the PAD's Annex 3 for Results Framework Analysis are explained in Section F of the Data Sheet.

key PDO indicators.[54] This manifested itself especially after 2009 when the TLSS was discontinued.

60. **M&E Implementation is rated *Modest*.** Despite inconsistencies in the RF, the level of effort to monitor progress towards PDO achievement was commendable. From the outset, special attention was paid by the Bank to establish a baseline for and measure the impact of health financing reforms. Thus, the baseline Patient Financial Burden and Satisfaction survey was made the priority task for the forthcoming HPAU.

61. An informal revision of the RF took place in May 2009 in order to improve clarity, relevance, and measurability of both PDO and IO indicators. As a result, monitoring of 12 PDO and 14 IO indicators was discontinued, a few new indicators added, and others were refined. The M&E of the project was downgraded from Satisfactory to Moderately Satisfactory only once in December 2010 given the lack of clear and consistent data on progress towards the PDO, especially for the two indicators relying on TLSS data. A revision of the overall M&E framework was attempted to ensure the indicators could be monitored regularly for the remaining two years of the AF2 implementation,[55] which would have required processing of a Level II restructuring of the project. This intention was later reconsidered in consultation with the Bank's ECA Quality department as the two main PDO indicators were considered achieved based on the original CBHP target values whereas it appears to have been confused that the (more optimistic) target values for the two PDO indicators set under AF2[56] overrode the original CBHP target values. Regrettably, this confusion had eliminated the last opportunity for correcting deficiencies in the project M&E.

62. **M&E Utilization is rated *Substantial*.** The MOH's capacity to use the produced data for policy planning and decision making has evolved over time, though at a slower pace than expected. Following the period of continuous overwhelming of the HPAU with the MOH's routine work—which left less time for HPAU's core analytical and M&E functions—remarkable progress was achieved in building demand from policymakers and other stakeholders for relevant and timely analytical inputs. Thus, the European Commission (EC) and WHO continued to support HPAU functioning after CBHP phased out, and the practice of having clear annual work plans for HPAU, allocating 80% of its time to analytical work, has been gradually followed. Moreover, the continuous use of surveys, NHA, and MTBF was embedded in the Comprehensive Health Care Strategy, which also includes a comprehensive set of monitoring indicators for implementation review and policy planning through the participatory Joint Annual Review conferences initiated since 2011 under MOH leadership.

63. Notably, the State Committee for Investments and State Property Management (SCISPM) has committed to increasingly linking sectoral monitoring data with strategic monitoring and planning at the national level through a comprehensive database of all donor investment projects in the country and enhancement of sectoral indicators to ensure the impact, sustainability, and consistency of all investments with national priorities.

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[54] ISR No.10 dated December 10, 2010.
[55] ISR No.10 dated December 10, 2010.
[56] Targets for these two indicators were established under AF2 at or below the already attained, pre-crisis levels based on TLSS 2007 data. The unavailability at the time of AF2 processing of the TLSS 2009 data, which was already reflective of the impact of the economic crisis, resulted in the inability of the Bank team to establish realistic target values for these two indicators.

64. The project investments in PHC- and hospital-based MIS and enhancing health statistics quality have contributed to improving the accuracy and reliability of data for monitoring, planning, and decision making purposes. The EC plans to further develop HMIS at the national level, with potential use of the CBHP-deployed facility-based MIS, present considerable room for system-wide improvements in the M&E capacity in Tajikistan.

2.4 Safeguard and Fiduciary Compliance

65. **Safeguards compliance is rated *Moderately Satisfactory.*** The original Project was rated C and was limited to the rehabilitation of small PHC facilities (1-5 rooms), with potential replacement of a few facilities within the existing building footprint.[57] These were expected to pose minimal environmental risks. With no outpatient surgery or other procedures, no medical wastes were envisaged and safe disposal of "sharps" was to be specified, and no land acquisition was expected. Nonetheless, with a potential replacement of health facilities, the Recipient, though not required for a Category C project, had prepared, approved, and publicly disclosed in November 2005 an Environmental Management Plan (EMP). The Plan covered issues pertinent to small-scale civil works and, according to the then existing national Sanitary Norms and Rules, envisaged a site-specific environmental screening and review process.[58]

66. As part of the Bank-wide portfolio review of investment projects conducted in December 2008, the Bank team found that out of the 55 planned facilities, 11 were being built on new sites, with the construction half way completed. The Bank team ensured all necessary due diligence by: (i) requesting the Recipient to immediately suspend all the construction works on those sites; (ii) exploring the reasons of the need for construction on new sites; and (iii) consulting with the Bank's safeguards unit. It was found that: (i) the 11 new PHC facilities had to be constructed on new sites because the rented premises of other facilities (schools, utility rooms, etc.) where the old PHC centers were located had to be vacated; (ii) they were constructed on new sites previously approved by the local authorities in strict compliance with the Oblast Development Master Plans, environmental evaluation, and the country's legislation; (iii) the new construction was on territories that had not been populated before, were free of settlement, greenery, buildings or any economic activity, and nobody had lived before on those territories; and (iv) no resettlement took place according to the local authorities; (v) the land for new construction sites was appropriately allocated based on four commonly required legal documents.[59] In addition, an independent social assessment commissioned by the Bank on the due diligence of land acquisition for the 11 PHC centers confirmed that no land acquisition or involuntary resettlement took place, thus, the Bank's Operational Policy 4.12 on involuntary resettlement was not triggered.

67. As a result of the findings and a review by the Bank's Safeguards Unit of the original EMP—which was found acceptable—the following actions were taken by the Bank: (i) the Environmental Category was upgraded from C to B, along with processing the AF1, in March 2009 for the undisbursed CBHP funds pertaining to the construction of

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[57] Section 5: Environment and Annex 10 of the PAD.
[58] Environmental Management Plan for the Tajikistan Community and Basic Health Project, October 2005.
[59] Project Paper for the first Additional Financing (Report No.47561-TJ), April 7, 2009.

the 11 PHC centers; (ii) site-specific EMP checklists for the 11 PHC facilities were prepared by the PIU/MOH in accordance with the original Project-wide EMP, approved by the Bank, and included in civil works contracts before the continuation of construction works; (iii) the AF1 was assigned Environmental Category B, and the original EMP was updated by the MOH in line with Bank requirements for Category B projects and publicly disclosed in March 2009. [60]Subsequently, the Bank team continued to ensure compliance of the civil works with the provisions of the project-wide and site-specific EMPs. As a result, the project did not have significant or irreversible negative environmental impact at the construction phase of the facilities.

68. Although the handling and processing medical waste was the responsibility of the rayon SES, the Bank recommended on several occasions to: (i) revisit the utilized incinerator design to ensure destruction of all medical waste items; and (ii) assess functional efficiency of the medical waste collection and processing system in order to minimize possible health hazards. By November 2012, this issue was addressed through a MOH decision to build a new type of small incinerator based on improved and tested design, and with all technical work being underway.

69. ***Financial Management is rated Satisfactory***. The PIU had adequate capacity throughout the project period and performed all financial management functions as required. Additional internal controls were implemented by the PIU for the Food Price Crisis AF, as required by the Bank, to ensure transparency and control over the selection of beneficiaries and implementing NGOs, as well as the delivery and distribution of food and nutrition supplements. The internal controls were further strengthened in 2010 to eliminate the practice of cash payments for training expenditures. The customized accounting software was updated as necessary in order to produce acceptable financial reporting for all the grants. Disbursements under the project were consistently on or ahead of schedule and the proceeds of the grants were disbursed as planned.

70. Although external audit reports were usually submitted in a timely manner and found acceptable by the Bank, the reports for CY2010 and CY2011 were delayed due to the late selection of an auditor by the SCISPM under the centralized annual block audit arrangement. As part of the project closing procedures, the PIU opened an escrow account for the payment of the final audit to be conducted in May 2013, with a report expected by June 30, 2013.

71. ***Procurement is rated Satisfactory.*** The PIU had adequate procurement capacity and procurement activities were implemented satisfactorily for the most implementation period based on a regularly updated procurement plan. The detailed Project Operational Manual ensured clarity of roles among PIU staff vis-à-vis procurement activities, and the availability of procurement staff in the Bank's country office enabled regular interaction on procurement issues.

72. Initial delays in the first round of the micronutrients and food packages procurement under the Food Price Crisis AF occurred due to the increase in procurement workload and lack of technical expertise in the PIU in procurement planning for emergency assistance. The issue was addressed through: (i) the recruitment of an additional procurement assistant to support the implementation of the Food Price Crisis

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[60] Ibid.

AF; (ii) collaboration with UNICEF in procurement planning and supply of micronutrients, vitamins, and growth monitoring equipment; and (iii) application of the simplified shopping method with higher thresholds for the procurement of the first batch of food packages. The latter was allowed by the Bank in response to the urgent nature of the food crisis, based on OP/BP 8.00. At the same time, the PIU was required to develop a satisfactory distribution plan and oversight mechanism to ensure timely delivery of the food packages to the beneficiaries.

73. The recommendations from the four procurement ex-post reviews and a country fiduciary portfolio review (2008) conducted for the project were usually properly implemented by the PIU before the next mission. No major issues were identified during the reviews, with procurement processes considered compliant with the Bank's procurement guidelines.

2.5 Post-completion Operation/Next Phase

74. ***The transition arrangements*** for post-completion of CBHP investments are considered adequate, as demonstrated by: (i) the takeover of CBHP support to some MOH functions by other partners (e.g., by WHO and EC for HPAU; by USAID-funded QHCP for the MOH Press Center); (ii) incorporation of some other functions into MOH routine operation (e.g., donor coordination); and (iii) shared funding from oblast and rayon hukumats for FM training and maintenance of PHC infrastructure, and from local jamoats for operational costs of PHC facilities (e.g., fuel for generators). Also, the dialogue has continued with GOT on implementing the Health Sector Master Plan.

75. ***A proposed Health Services Improvement Project (HSIP)*** planned for early FY14 would focus on improving the coverage and quality of basic PHC services (mainly for MCH and NCD) by piloting performance-based financing (PBF) at the PHC level as well as continued investments in PHC infrastructure and capacity building. The HSIP also marks important transitions: to an explicit focus at the policy level on stimulating improvements in service quality, and from the PIU-based model to MOH-led implementation. In addition, an Institutional Development Fund (IDF) grant [61] will support the piloting of full per capita financing in PHC facilities of selected rayons in the country.

3. Assessment of Outcomes

3.1 Relevance of Objectives, Design and Implementation

Rating: ***Substantial***

76. *Objectives*. The project's objectives were, and remain, highly relevant. They fully reflect the country's current development priorities declared in the NDS for 2006-2015, PRS for 2010-2012, and Comprehensive Health Sector Strategy 2010-2020. [62] The objectives are also consistent with the Bank's Country Partnership Strategy for FY2010-

[61] Approved in December 2012 in the amount of US$0.5 million.

[62] The priorities specified in these strategies relate to improving public administration and developing human potential; promoting sustainable improvements in living standards, particularly of vulnerable groups; and improving quality, equity, efficiency and cost-effectiveness of the health system through *inter alia* an increase in public funding, in particular to primary health care.

13 aiming to maintain access to critical public services and to strengthen the quality of public services provided in order to enhance human capital potential.

77. *Design.* The design was, and remains, substantially relevant. Project components built on the previous project's lessons and comprehensively addressed the key sector issues that retained their relevance throughout. The combination of investments in physical infrastructure and intellectual capacity, and reinforcement of investment activities with policy-based budget support remained relevant and effective design features. However, a better defined and streamlined RF could have enabled better measurement and demonstration of the PDO achievement.

78. *Implementation arrangements* based on a PIU model were relevant in the context of the existing weak institutional capacity in the health sector. However, the arrangements for gradually mainstreaming the stand-alone PIU into the MOH did not materialize fully in practice and, therefore, considered modest.

3.2 Achievement of Project Development Objectives
Rating: ***Substantial***

79. Overall, compared to the situation prior to CBHP, the project, with co-financing from SIDA and SDC, made an important contribution to improvements in some key areas, including (i) the strengthening of the MOH's stewardship capacity; (ii) building capacity for delivering PHC services and implementing structural reforms at all levels; and (iii) improving access to, utilization of and patient satisfaction with PHC services in project-supported rayons.

80. As illustrated in Table 1 below, the targets for nearly all the IO indicators were achieved or partially achieved, as were most of the PDO indicators (refer to Annex 2 and Section F of the Data Sheet for details). However, two PDO indicators—related to the percentage of households not seeking care because they cannot afford it and the share of health in household expenditures—presented a mixed picture vis-à-vis achievement of the PDO1.

Table 1. Consolidated End-of-Project Status of Project Indicators

Status	**10 PDO Indicators**		**36 Intermediate Outcome Indicators (IO)**[63]		**% of Total**
	6/PDO1	**4/PDO2**	**15 IO/PDO1**	**21 IO/PDO2**	
Achieved	**1**	**1**	15	16	71.7%
Partially Achieved	**3**	**2**	0	4	19.6%
Not Achieved		**1**	0	1	4.3%
Impossible to measure	**2**				4.4%

PDO1: to increase access to, utilization of, and patient satisfaction with health services in project-supported areas; PDO2: to build capacity and efficiency at national, oblast and rayon levels in

[63] One IO indicator for PDO1 and two IO indicators for PDO2 were excluded from these calculations because of some overlaps between original indicators, those included under AF1, and Core Sector Indicators due to different formulations.

administering a basic package of health benefits and introducing financing reforms in primary health care.

PDO 1 – increase access to, utilization of, and patient satisfaction with health services in project-supported areas.

81. The strengthening of the PHC infrastructure, FM-based services, and outreach; involvement of local communities; and implementation of the BPMCS has led to increased utilization of health services in the pilot rayons. Although the changes have been uneven, the evidence shows that the number of PHC visits per capita per year in the 7 pilot rayons has increased by over 70% on average in 2012 compared to 2009, and over 60% compared to 2006. The PHC gate-keeping function established through a referral system and the BPMCS implementation have resulted in improved access to hospital services and financial protection of vulnerable and exempted population groups in the BPMCS pilot rayons. While the share of hospital admissions of provisionally exempted groups before the BPMCS implementation was around 30% on average, this share ranged in 2011 between 43.7% in Sarband, 55.6% in Spitamen, and 65.2% in Nurek. Furthermore, deliveries have increasingly constituted the largest share of all the admissions of exempted groups under the BPMCS, which ranged in 2011 from 47.9% in Spitamen to 61.4% in Nurek to 64.9% in Sarband.[64] The findings from the final Patient Financial Burden and Satisfaction survey conducted in late 2009, after 15 months of the 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. The survey also confirmed that—when formalized co-payments, informal payments to medical personnel, and payments for drugs, medical supplies and lab tests were taken into account—the average amount of payment by patients decreased by 11% in the pilot rayons whereas it increased by 21% in the control rayons.

82. The increased utilization of health services in the pilot rayons has translated into improved health system performance indicators: (i) increase in the number of pregnant women seeking antenatal care from the baseline of zero in 2005 to 2,889 in 2009 and to 4,229 in 2012; (ii) 37% reduction in home deliveries from 35,063 in 2005 to 21,954 in 2012; and (iii) some improvements in immunization coverage and infant and child mortality rates[65]. Evidence also indicates to increased satisfaction with health services in project supported areas. According to data from the same survey of 2009, the level of satisfaction with PHC services was 92%, and 93% for hospital services. The CBHP Impact Assessment of 2010[66] explained behavioral reasons for such unusually high values but also confirmed, using proxy indicators, that the population of the pilot rayons was more satisfied with provided health services than the population in non-pilot rayons, taking into account the comparison of the situation before and after project interventions. Another external evaluation showed that community satisfaction with services at PHC facility level increased in pilot rayons covered by Aga Khan Foundation and AKTED

[64] Final Completion Report for 2006-2012, Vol. I-II, Project Implementation Unit/Ministry of Health, December 2012; Ministry of Health data.
[65] External Evaluation of Community and Basic Health Project (CBH project) - Component C, University Hospitals of Geneva, November 2010
[66] Prepared by INTRAC & Dynamic Management in September 2010.

under Component C between 2006 and 2009 from 60% to 85% and from 58% to 84%, respectively.[67]

83. However, an accurate measurement of the end-of-project achievement status of the two PDO indicators which relied on TLSS was not possible due to the discontinuation of TLSS after 2009 and the issue of comparability of data from other sources.[68] One might speculate that the target values set under AF2 were not achieved based on the data from TLSS 2009. However, a sensible assessment should take into account the negative effects of the 2008-2009 economic crisis,[69] which led to a reduction in household incomes due to reduced migrant worker remittances from abroad[70] and an overall increase in the price of food products. In addition, the prices of pharmaceuticals, most of which the country had been importing, increased significantly due to the elimination of the related import duty relief starting February 1, 2011.[71] Thus, the aggregate impact of the crisis was to directly and negatively influence the achievement of these two PDO indicators, and it is hard to know at the time of writing the exact extent to which the project activities have increased the households' access to health services. Still, what available evidence on the improved financial protection and utilization of health services in the pilot rayons presented above suggests that the project indeed had an ameliorating impact even if some end-of-project targets might not have been achieved.

PDO 2 – build capacity and efficiency at national, oblast, and rayon levels in administering a basic package of health benefits and introducing finance reforms in primary health care.

84. The RF—especially after the informal revision in May 2009—did not include PDO indicators directly linked to this PDO. However, the important achievements in building capacity and efficiency at all levels—as demonstrated by the respective IO indicators—are evident from: (i) the MOH's engaging HPAU as an increasingly relevant instrument for evidence-based policymaking; (ii) adopted key strategies and enhanced stewardship role of the MOH laying the foundation for sector development in the medium term; (iii) strengthened M&E framework for the health sector and improved coordination among the MOH, other GOT agencies, and DPs in addressing the needs of the health sector through Joint Annual Reviews; (iv) MOH's strengthened capacity for regular and targeted communication on health reform issues through a variety of communication

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[67] External Evaluation of Community and Basic Health Project (CBH project) - Component C, University Hospitals of Geneva, November 2010

[68] Based on a 2011 household survey on access to and quality of public services conducted in five regions of Tajikistan under the Bank-supported "*Mainstreaming Governance in Tajikistan* Program", among those who needed outpatient / inpatient treatment in Soghd oblast, 14.3% / 6.9%, respectively, did not sought treatment because they could not afford it. In Khatlon oblast, the responses led to percentages of 2.9% / 7.8%, respectively. Compared to the data from TLSS 2009 (15% for Soghd and 42% for Khatlon), these additional data show slight improvement in access to health services in Soghd and significant improvement in Khatlon. Conversely, the additional data show that share of health in household expenditure has increased in both oblasts, with 2.5% / 5.4% on outpatient / inpatient care in Soghd and 4.1% / 7.1% in Khatlon. However, due to possible differences in methodology these data must be interpreted with caution.

[69] Hou, X., et al. (forthcoming, 2013). "The Health Sector and Economic Downturns: Learning from Failures". World Bank: Washington DC.

[70] Impact of Migration and Remittances on Household Welfare and Poverty in Tajikistan, Tajikistan Statistics Agency, August 2010.

[71] Article 17 of the Law on State Budget for 2011 (Nos.714, 765, 767).

channels at different levels; (v) training abroad of over 150 specialists at all levels in financing and management reforms and PHC and hospital finance planning functions internalized at the central and sub-national levels; (vi) two OHDs and health facilities in 44 rayons of the Soghd and Khatlon oblasts—which represent two thirds of the total number of rayons in the country—fully equipped, furnished, provided with basic information systems, and with all managerial, financial, and statistical staff trained in computer literacy, HMIS, health management, and financial management and performing their expanded functions; (vii) streamlined statistical reporting and routine use of HMIS by facilities and rayon-level managers for business planning, management, and reporting purposes; (viii) procurement capacity built at the MOH, with "Qualified Procuring Entity" status and authorization awarded to conduct tenders autonomously.

85. The 2012 targets for one PDO indicator and one IO indicator were not fully achieved within the project period due to the GOT decisions to implement full capitation and expanded BPMCS in a more phased approach in post-project period, mainly due to fiscal constraints. However, the CBHP did support the introduction of the PHC per capita financing in two thirds of the country where none existed before, and the experiences from piloting the BPMCS—along with other DPs—and enhanced capacity for evidence-based policymaking enabled GOT to take informed decisions for subsequent implementation phase.

3.3 Efficiency

Rating: ***Substantial***

86. The project investments created both direct and indirect benefits for the population in project supported areas as well as for the public administration and the health system in general. The present value of project benefits are estimated at about $17.4 million and the present value of costs amount to $13.9 million (component C), implying a benefit/cost ratio of 1.2 and an economic rate of return of 23% (refer to Annex 3 for details).

87. The fiscal sustainability analysis contained in the PAD was repeated using actual project costs to estimate the true recurrent cost impact. It showed that the recurrent project expenditures represent just 0.08% of total public health expenditures. Given the six-fold increase of Tajikistan's economy over the past seven years, significant increase in public health expenditure over the last decade, and the healthy economic outlook, the project's recurrent cost impact is negligible and the investments are likely to be sustainable.

3.4 Justification of Overall Outcome Rating

Rating: ***Moderately Satisfactory***

88. Although the project's relevance, efficacy, and efficiency are all rated Substantial, the project's overall outcome is considered Moderately Satisfactory, mainly because progress towards efficiency objective could not be scaled up fully towards the established target values within the project period due to the related GOT decisions conditioned by fiscal constraints.

3.5 Overarching Themes, Other Outcomes and Impacts

(a) Poverty Impacts, Gender Aspects, and Social Development

89. The project's poverty, gender and social development impact was especially visible in GFPCR interventions. Nutritional support, education, and child development monitoring services provided to pregnant and breastfeeding women living in lower-income areas contributed to their households' socioeconomic wellbeing, children's cognitive development and prevention of illness, thereby reducing impoverishing effects of expenditures caused by ill-health. Due to the high level of poverty in the country[72] and labor migration of the primarily working-age rural men, the strengthened PHC networks mostly benefitted women, children and the elderly from poor rural households in the neediest rayons. Finally, the financing reforms aimed to provide financial protection to the poor by enhancing equity in financing of health services.

(b) Institutional Change/Strengthening

90. Project investments resulted in considerable institutional development impact. This included both strengthening of the MOH, Republican Center of Medical Statistics and Information (RCMSI), OHDs, FMTCs, PHC facilities, and hospitals' physical infrastructure and capacity to fulfill their expanded functions better. Capacity building also involved the development of important strategies, tools, and mechanisms for the sector. Substantial institutional development was also evident in the empowerment of local communities to address their health and development needs through uniquely tailored and well-tested mechanisms. Most importantly, the project laid the foundation for the advancement of structural reforms by building experience, understanding, and capacity vis-à-vis policy, financial and managerial aspects of such reforms at the central, oblast and rayon levels.

(c) Other Unintended Outcomes and Impacts

91. The PIU and involved PHC facilities gained the unanticipated experience of implementing emergency humanitarian assistance. The project also expanded the health management and financial management training to specialists from three additional rayons after ADB support to those rayons was phased out, thus covering all the 44 rayons of the Soghd and Khatlon oblasts.

3.6 Summary of Findings of Beneficiary Survey and/or Stakeholder Workshops

N/A

4. Assessment of Risk to Development Outcome

Rating: ***Moderate***

92. The achievements attained are encouraging with standardized approach to PHC infrastructure, institutionalized community development mechanisms, and a comprehensive PHC approach with FM courses incorporated in the university pre-diploma curriculum and effort to further develop CME. The developed core analytical tools and functions are increasingly being internalized by the MOH, and DPs continue to support the MOH in this transition. Some moderate risks that development outcomes would not be maintained remain due to the: (i) uncertain policy environment vis-à-vis

[72] At the end of 2007, 53.5% of the population was poor, and 17.1% extremely poor, according to TLSS 2007.

structural reforms; (ii) GOT's limited ability to fully implement the rationalization plan; and (iii) potential lack of sustainable institutional ownership of the HMIS development. However, a renewed GOT commitment to reforms, core capacity for implementation created, and improved donor coordination compensate the risks to a large extent and make project gains unlikely to be reversed.

5. Assessment of Bank and Borrower Performance

5.1 Bank Performance

(a) Bank Performance in Ensuring Quality at Entry
Rating: ***Moderately Satisfactory***

93. Despite the tight preparation timetable and budget, the design was well-thought, comprehensive, and well-targeted to the most pressing issues. It built on the prior rigorous analytical work and lessons from the preceding PHCP, envisaged a phased approach to reforms, and leveraged complementarities with the Bank's policy-based operations and other DPs' work. Key decisions—such as the retention of the core staffing of the PHCP PIU to implement the CBHP—were based on a solid assessment of the situation and substantiated agreement with the government. Though an EMP was not required for a category C project based on the prevailing practice and OPCS guidance at the time of appraisal, its preparation and public disclosure for this project was a good practice.

94. However, there were deficiencies in the M&E framework, which hindered adequate measurement of the progress towards PDO achievement. Risks related to the policy and fiscal environment—aggravated largely by the economic crisis—were either unforeseen or underestimated.

(b) Quality of Supervision
Rating: ***Moderately Satisfactory***

95. In general, the allocation of resources, supervision support from SDC and SIDA, and exploration of additional funding sources enabled the task team to supervise the project well, including effective response to the needs for international TA and implementation of innovative activities. Comprehensive aide memoires provided detailed reviews of the implementation progress, policy and implementation issues faced, and recommendations for specific, time-bound actions. Likewise, the prepared ISRs provided the Bank management with a candid overview and assessment of project performance and policy issues. The task team's effort to ensure fiduciary and safeguards compliance and progress in meeting intermediate results, including civil works and disbursement targets, was commendable.

96. The 2008 Mid-Term Review (MTR), joined by SDC and SIDA, focused on ensuring impact and sustainability of project investments and actions to remedy emerging issues, including *inter alia* the need to reallocate funds to higher-than-expected costs of civil works and to improve the project's results framework.

97. There was some inefficiency in the Bank team staffing in the early years of implementation, and insufficiency of implementation-focused policy dialogue was a shortcoming during supervision. No appropriate revision of the PDO indicators and monitoring arrangements took place after TLSS was discontinued despite the obvious

challenges in reliably measuring the progress toward achieving the PDO. Had this been done, the project's substantial achievements and impact could have been demonstrated better than was eventually the case.

(c) Justification of Rating for Overall Bank Performance
Rating: ***Moderately Satisfactory***

98. The overall rating of Moderately Satisfactory is based on the Bank performance during the preparation and supervision phases, as discussed above.

5.2 Borrower Performance

(a) Government Performance
Rating: ***Moderately Satisfactory***

99. The ownership and commitment to the project objectives by the GOT—including the MOH, MOF, National Board on Health, and Aid Coordination Unit/CSISPM—was strong during the preparation as evidenced by its close involvement in preparation activities; adoption of the sensible HSFS for 2005-2015; commitment to key health reforms stated in the LDP; and the signing and effectiveness of the DGA within reasonable time. In addition, the GOT: adopted, although with occasional delays, resolutions that provided legal bases for piloting BPMCS and per capita payment reforms; retained the PHCP PIU to implement the CBHP and manage civil works; and ensured adequate transition arrangements for regular operation of supported activities after project closing.

100. Conversely, delays in some activities occurred during early implementation period due to changes in MOH leadership; some policy reversals took place despite the initial commitments expressed in the LDP; and overall political buy-in from the GOT for rolling out the envisaged health financing reforms attenuated after 2009. The Health Sector Master Plan has not been implemented fully in the absence of envisaged changes in the provider payment system and broad stakeholder support for the rationalization although it was used as a reference for constructing PHC facilities under AF2 as well as to inform the design of the HSIP and KfW hospital investment program.

(b) Implementing Agency or Agencies Performance
Rating: ***Satisfactory***

101. The project was ready for implementation in due course, with all systems in place and cost estimates, job descriptions for the PIU staff, and first-year implementation plan ready by the appraisal stage, and a comprehensive POM developed by the PIU without any support from international TA by project effectiveness.

102. During the implementation phase, the PIU effectively carried out all aspects of project management. All audits of the PIU's performance were unqualified, except for delays in submitting external audit reports for 2010 and 2011, which was beyond the PIU's control. The PIU responded flexibly and efficiently to changing circumstances, including adjustments in procurement and civil works to constrained finances occasioned by the economic crisis, coordinating the implementation with other partners, and supervising a complex project in a difficult implementation environment while maintaining fiduciary integrity. The MOH proposal to use the PIU to administer the US$92 million grant from the Global Fund for AIDS, Tuberculosis and Malaria and three

occasions of AF for CBHP from IDA testified to the PIU's strong track record in project management and disbursement.

103. As contemplated at the design stage, the PIU exercised utmost due diligence in supervising the civil works, which is especially impressive given the scattered distribution and remoteness of the facilities and the difficulty of completing a far-flung set of facility constructions on time and at reasonable cost. A slightly larger number of quality shortcomings (than had usually been the case) were reported in the November 2012 mission aide memoire. The major observed factor was the rush to complete the construction on time, which started late due to the long winter of 2011-12, and secondarily a perhaps somewhat weakened supervision effort by the PIU in the last year of the project. The PIU's involvement in policy issues was to a large extent fueled by the MOH's insufficient technical capacity and the PIU's heavy focus on timely implementation of its work program, which in many aspects was dependent on policy actions to be taken by GOT.

(c) Justification of Rating for Overall Borrower Performance
Rating: ***Moderately Satisfactory***

104. The overall performance of the Borrower is rated Moderately Satisfactory based on the GOT and PIU performance, as discussed above.

6. Lessons Learned

105. The following are key lessons that have been derived from the implementation of this project:

106. **Critical to ensure adequate assessment of risks and challenges at appraisal and during project implementation.** Investment lending on its own is not sufficient when embarking on complex structural reforms; a mix of policy-based budget support and implementation-focused SIL has the potential of raising the effectiveness of reform interventions. Still, when intended policy reforms are not addressed directly by an investment operation—but coordinated on a critical path with other Bank operations or programs of other DPs—assessment of risks should comprehensively cover and prioritize all aspects that can affect the project interventions, including fiscal and capacity constraints and political complexity of initiating such reforms. Expectations for implementation of reform projects in countries with changing political environments should be realistic and potential implementation delays should be anticipated and proactively addressed, especially in the case of complex projects covering a wide range of activities.

107. **Government ownership and capacity development.** Strenuous and continuous efforts are critical for building technical and implementation capacity in the line government agency implementing a reform project, especially when capacity limitations are recognized at the design stage. Such efforts should properly address institutional, capacity imbalance, and motivation aspects through clear definition of roles, accountability arrangements and provision of incentives. Importantly, motivation needs to be provided to civil servants when projects of this nature and complexity are to be implemented by them. Although building of MOH's implementation capacity by integrating the PIU into the MOH over time was envisaged at CBHP design stage, it happened in a more limited degree than expected because of (i) the legal status of the PIU as a stand-alone legal entity with a broad range of entitlements, and (ii) the lack of

adequate incentives on both sides to stimulate the transfer of knowledge and implementation capacity from the PIU to the MOH. This in some cases negatively affected ownership of project outputs by the MOH. At the same time, this project demonstrated that close work with oblast/rayon authorities, communities, and population was critical for building broad ownership and support to project activities at lower levels.

108. **Need for effective coordination.** Structural reforms have several prerequisites, such as a shared and clear vision for reforms, building capacity and a critical mass of supporters upfront, concerted efforts towards the vision from all stakeholders involved, and strong champions for reforms. Therefore, in sectors 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. Timely sharing of all relevant information, joint supervision of projects and regular health summits focused on relevant topics can serve as effective tools for ensuring consistency of policy dialogue with the government and positive aggregate impact on the sector development. More importantly, such coordination initiatives should be initiated upstream among DPs' headquarters offices at a program planning stage to avoid constraints in coordination at the country level when DPs' respective programs/projects have been pre-defined at their headquarters.

109. **Appropriate staffing of Bank teams is critical.** The right composition of a task team, including specialized technical and strong task management and operational skills, is required to supervise complex projects in challenging environments. Continuous policy dialogue on key policy issues with all relevant stakeholders from the outset, strong supervision and capacity building are particularly critical when embarking on complex financing reforms in politically challenging and fiscally and capacity-wise constrained environments.

110. **Streamlined results framework and adequate monitoring arrangements are essential to guide implementation and measure results.** Although the project in many respects was exemplary in its inherent relevance to Bank policies and country strategies, it proved once again the critical need for performance indicators to be carefully selected at the design stage or appropriately revised during implementation.

111. **Safeguards.** Lack of full compliance with the Bank's safeguards requirements in projects involving civil works in a country with weak overall capacity is a common occurrence. The Bank teams should anticipate that construction on new sites might become necessary even if not initially envisaged and, therefore, ensure an appropriate mechanism is in place to confirm the location and nature of works prior to their initiation. Moreover, relevant and adequate capacity building for implementing agencies is critical for understanding of and compliance with the Bank's requirements. Collectively, these will ensure that the Bank is notified in due time and all necessary assessments and plans are prepared together with the Client before civil works start.

7. Comments on Issues Raised by Borrower/Implementing Agencies/Partners

(a) Borrower/implementing agencies

112. The ICR team acknowledged most of the MOH's comments enclosed in full in Annex 7. An effort was undertaken to obtain from other possible sources additional objective evidence supporting or refuting the initial rating of overall outcome as Moderately Unsatisfactory. As a consequence, additional information provided by the

Ministry of Health and external survey data[73] (re-calculated for the ICR purposes) has led to the ICR team's conviction that the overall outcome rating should be upgraded to Moderately Satisfactory. All the relevant comments have been incorporated as far as possible in the final version of this ICR.

(b) Cofinanciers

(c) Other partners and stakeholders

[73] Household survey on access to and quality of public services conducted in 2011-2012 in five regions of Tajikistan under the Bank-supported *Mainstreaming Governance in Tajikistan* Program.

Annex 1: Project Costs and Financing

(a) Project Cost by Component

Components	Appraisal Estimate (USD millions)	Actual/Latest Estimate (USD millions)	Percentage of Appraisal
A. Strengthening Policy, Planning and Donor Coordination	2.70	2.26	83.9% [74]
B. Implementing Organizational and Financing Reforms	5.56	5.42	97.3%
C1-3. Strengthening PHC in Selected Rayons	14.09	15.62	110.9% [75]
C4. Food Price Crisis Grant	4.00	4.00	100.0%
Component D. Project Coordination and Capacity Building for Implementation	2.44	3.23	132.5% [76]
Contingencies and Unallocated funds	0.20	-	0.0%
Project Preparation Advance	0.30	0.24	80.0%
Total	**29.29**	**30.77**	**105.0%** [77]

(b) Sources of Financing

Sources of financing	Appraisal Estimate (USD millions)	Actual/Latest Estimate (USD millions)	Percentage of Appraisal
IDA H195-TJ	10.00	10.62	106.2%
SIDA TF056448	6.11	6.68	109.3%
SDC TF090142	1.18	1.18	100.0%
IDA H461-TJ	5.00	5.19	103.9%
IDA H586-TJ	3.00	3.10	103.3%
TF092349 (C4)	4.00	4.00	100.0%
Total	**29.29**	**30.77**	**105.0%**

(c) Project Cost by Category

Categories	Appraisal Estimate (USD millions)	Actual/Latest Estimate (USD millions)	Percentage of Appraisal
Civil Works	6.17	8.46	137.2% [78]

[74] Due to cost savings under a range of activities incl. minor rehabilitation works in MOH, international consultancies, workshops and round tables.

[75] Due to (i) increased cost of civil works, goods, and international consultancy services, and (ii) rehabilitation of additional facilities under AF1 and AF2.

[76] Due to significant increase in Operating Costs category (see footnote for Operating Costs in Table (c).

[77] Over-spending in Components C and D were compensated through savings in Components A and B, Project Preparation Advance savings, and Contingencies. Overall over-spending is explained by currency gains due to appreciation of SDR and Swedish Krona against USD.

Goods	12.09	12.07	99.9%
Consultants' services, training and audit	9.41	8.54	90.8%
Operating Costs	1.12	1.46	129.5%[79]
PPF	0.30	0.24	80.1%
Unallocated	0.20	-	0.0%
Total	**29.29**	**30.77**	**105.0%**

(d) Reallocations of IDA H195-TJ funds (in SDR equivalent)

Categories	Original allocation	First reallocation, October 30, 2008		Second reallocation, August 30, 2010	
		Amounts reallocated	Categories after reallocation	Amounts reallocated	Categories after reallocation
(1a) Works	1,627,703		1,627,703		1,830,959[80]
(1b) Goods	2,236,755		2,236,755		2,405,401[81]
(1c) Consultant's Services including audit and training	2,095,542		2,095,542		2,147,267[82]
(2) Operating Costs	210,000		326,000		349,000
(3) Refunding of Project Preparation Advance	210,000		210,000	19,627 to Category (1); 23,000 to Category (2)	167,373
(4) Unallocated	520,000	116,000 to Category (2)	404,000	404,000 to Category (1)	-
Total	**6,900,000**		**6,900,000**		**6,900,000**

Note:
In accordance with the Grant Agreement No H195-TJ, Category (1) includes works, goods, services, training and audit in the original amount of SDR 5,960,000. For this reason, works, goods, and services under the Category (1) in Table (d) are provisionally broken down into respective sub-categories based on each sub-category's weight in the consolidated amount of the Grant No. H195-TJ and co-financing Grant from SIDA No.TF056448.

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[78] Over-spending is explained by the increase in construction materials prices and cost of sub-contractors services due to high inflation, as well as rehabilitation of additional facilities under AF1 and AF2.

[79] Due to (i) reallocations of funds to Operating Costs category on two occasions (see Table (d)) related to (a) initial underestimation of costs, (b) increase in costs related to administration of additional activities, and (c) increase in costs caused by the financial crisis; (ii) increase in value of the international consultancy contract for development of HMIS which originated from the increase in income tax rate for non-residents from 15% to 25% starting January 2010, according the amended Tax Code; and (iii) and currency gains due to appreciation of SDR and Swedish Krona against USD.

[80] 203,256 SDR from Category (4) for civil works under Sub-component C1.

[81] 168,646 SDR from Category (4) for goods under SubcomponentsSubcomponents A2, B2, C1, C3.

[82] 51,725 SDR from Categories (3) and (4) for services under SubcomponentsSubcomponents A1, B1, C3.

Annex 2. Outputs by Component

Component	Planned outputs at Appraisal	Actual outputs / outcomes at ICR
Component A: Strengthening Policy, Planning, and Donor Coordination in the Ministry of Health		
Sub-component A1. Policy Formulation and Analysis	(a) Minor renovations in MOH premises to house HPAU (b) Establishment of HPAU in MOH (c) Local (3) and intl.(1) TA for HPAU (d) Office equipment, furniture, and operating costs for HPAU (e) 3 out-of-pocket payment and patient satisfaction surveys, 2 public expenditure tracking surveys (f) NHA (development and institutionalization) (g) Training, workshops, study tours	(a) Renovation of MOH premises to house HPAU (b) HPAU established through MOH Order No.413 dated July 14, 2007, staffed with 5 local and 1 intl advisor, and integrated into the MOH functioning (c) 3 surveys on patient financial burden and satisfaction (d) Surveys on introduction of per capita financing and paid hospital services (e) 2 rounds and institutionalization of NHA (f) HPAU analytical inputs to the Comprehensive Health Care Strategy 2010-2020, data collection for Health Sector Master Plan, sessions of the Donor Coordination Council and Joint Annual Reviews of Comprehensive Health Care Strategy implementation (g) HPAU inputs to the MOH's M&E activities (h) Independent Assessment of CBHP Impact
Sub-component A2. Strategic and Operational Planning	(a) Office equipment, furniture, and operating costs for WGS (b) Local (3) and intl (1) TA (c) 3 new sub-sector strategies and comprehensive sector strategy (d) Health Sector Master Plan (e) HR Rationalization Plan (f) Training, workshops, seminars	(a) WGS established, staffed with 3 local staff, and had supported 44 MOH working groups (b) Database of functioning MOH working groups compiled (c) Comprehensive Health Care Strategy 2010-2020, including 4 new sub-sector strategies developed and adopted (d) Health Sector Master Plan for 2011-2020 developed and adopted (e) Software procured and GIS for the health sector developed, including over 300 maps with indication of 3,158 health

		facilities (f) Program for HR Development for 2011-2015 developed
Sub-component A3. Donor Coordination	(a) Short-term logistical support for biannual sector review conferences	(a) Database of donor-funded projects compiled (b) Over 10 health sector review conferences / summits conducted (c) Designated staff position on donor coordination introduced into MOH organizational chart
Sub-component A4. Public Relations and Communication	(a) Office and media/communication equipment, furniture, and operating costs for PR&C (b) Local (4 central and oblast-level) and intl (1) TA (c) Public Relations and Communication Strategy (d) PR&C activities (communication programs/campaigns)	(a) MOH Press Center and Soghd and Khatlon oblast press centers fully equipped, staffed and trained (b) Public Relations and Communication Strategy for 2007-2010 developed and implemented (c) MOH website designed and maintained (d) Regular (daily/weekly/monthly) public communication through various channels at central and oblast levels, incl. 22,997 minutes of TV airtime; 9,260 radio events; 1,152 articles on the Internet; 368 articles in newspapers; and 29 press-conferences.
Component B. Implementing Organizational and Financing Reforms in the Health Sector		
Sub-component B.1. Strengthening PHC Management and Financing	(a) Office equipment and furniture for 41 rayons and 2 OHDs (b) Vehicles for 41 rayons and 2 OHDs (c) Training materials and teaching manuals (d) Local (2) and intl (1) TA for PHC Management and Training (e) Local (1) MOH Coordinator for HMIS (f) Local (11) MOH and Oblast Coordinators for Health Management Training (g) Local (1) and intl (1) TA for PHC HMIS Development (h) Training in PHC Policy Implementation (incl. computer and software skills)	(a) Office equipment for 2 OHDs and 51 PHC facilities in 41 rayons in Soghd and Khatlon oblasts (b) Furniture for 52 PHC facilities in 41 rayons (c) 41 Russia-made NIVA vehicles for 41 rayon PHC networks (d) 168 MOH and oblast specialists trained overseas in health financing reform (e) 15 trainers in Financial Management trained (f) Financial Management training modules developed for health services purchasers (7 modules) and PHC providers (12 modules) (g) Health Management

		training modules developed for health services purchasers (15 modules) and PHC providers (12 modules) (h) 58 specialists in Soghd and 48 specialists in Khatlon trained in Health Management (i) 754 specialists from PHC network trained in Financial Management, including 287 specialists in Soghd and 467 in Khatlon (j) 75 seminars / roundtables on per capita financing conducted with participation of 3,931 specialists (managers, economists, statisticians, representatives of financial units/bodies, local authorities, etc.) (k) Printed and disseminated in pilot rayons: -1,500 copies of Instructions on Health Staff Remuneration -1,600 copies of Comments on Labor Relationships and Remuneration in Health Facilities -1,500 copies of Instructions on Per Capita Financing (l) Analytical reviews of the pilot implementation of per capita financing (m) Business Planning software for planning and tracking utilization of PHC services and budget (n) Accounting software for rayon level PHC network (o) 628 specialists and managerial staff from 41 rayons trained in basic computer skills.
Sub-component B2. Strengthening Hospital Management and Implementing the Basic Program of Medical Care Services	(a) Office equipment, furniture, and operating costs for 41 CRH and 2 OHDs (b) Step-and-repeat (printing down) machines for RCMSI (c) Procurement of ICD-10 (d) Materials for information dissemination	(a) Office equipment for 249 hospitals in 41 rayons in Soghd and Khatlon oblasts (b) Furniture for 251 hospitals (c) 64 diesel generators for 2 OHDs and hospitals in 41 rayons (d) Financial Management

	(e) Local (4) and intl (1) TA for Hospital Management and Training (f) Local HMIS Coordinators (2) and IT Specialists (2) (g) Training in computer and software skills (h) Local (4) and intl (1) TA for Hospital HMIS Development	training modules developed for hospital providers (13 modules) (e) Health Management training modules developed for hospital providers (14 modules) (f) 489 specialists from 249 hospitals, OHDs, and medical statistics units trained in computer skills (g) 250 specialists trained in Health Management, incl. 102 in Soghd, 139 in Khatlon, and 9 from MOH (e) 261 specialists in Soghd and 350 specialists in Khatlon trained in Financial Management (f) 23 seminars on implementation of BPMCS with participation of 965 specialists (managers, chief physician deputies, economists, accountants, etc.) (g) Coordination Councils established in all 3 BPMCS pilot rayons (h) Visual information materials (incl. patient flow diagram, co-payment sizes, list of required documents etc.) printed and exhibited in all BPMCS pilot hospitals (i) Step-by-step instruction for implementation of BPMCS developed (j) Printed and disseminated in BPMCS pilot rayons: -2,140 copies of Program of State Guarantees and Instruction on Co-payments -5 million copies of blank forms of 13 types of statistical reporting and List of Essential Drugs -120,000 copies of booklets on implementation of BPMCS for the population (k) Analytical reviews of the pilot implementation of BPMCS (l) Hospital HMIS collecting data on case mix,

		discharges and cost structure (m) 45 versions of ICD-10 mini reference books, separately for each hospital department profile, developed, translated into Tajik language, printed in 12,340 copies, and disseminated to 6,520 doctors in 1,016 facilities in 41 rayons of Soghd and Khatlon oblasts
Sub-component B3. Strengthening MOH Oversight of Organizational Financing Reforms	(a) Local (1) and intl (1) TA for output-based budget formulation methods (b) Local (1) and intl (1) TA for MTBF (c) TA for health sector functional and legislative reviews	(a) RCMSI premises renovated (b) Consultancy report on output-based budget formulation methods (c) 3 seminars conducted, and 5 specialists attended regional workshop in Yerevan on output-based budget formulation (d) Consultancy report on development of NHA (e) 6 seminars on development of NHA conducted (f) Intl TA on development and introduction of HMIS in PHC facilities, hospitals and OHDs. (g) 28 regulatory documents on health financing reforms developed
Component C. Strengthening PHC in Selected Rayons		
Sub-component C1. Strengthening the PHC Infrastructure	(a) Rehabilitation or replacement of at least 50 PHC facilities in 2-4 rayons in Soghd and Khatlon oblasts (b) Renovation of Soghd OHD premises and 2 PHC facilities (c) Reconstruction of 7 PHC facilities in Nurek and Temur-Malik rayons in Khatlon oblast (d) Furniture for constructed / rehabilitated PHC facilities (e) Computers / printers and supplies (f) Medical and cold chain equipment (g) Radio-communication equipment (h) Sanitary vehicles and spare parts (i) Diesel generators (j) Solar voltaic panels for renovated PHC facilities (k) Vehicles, office equipment and supplies for local inspectors'	(a) 40 PHC facilities replaced in 7 rayons in Soghd and Khatlon oblasts (b) 23 buildings renovated, incl. 21 PHC facilities in 7 rayons, and Soghd and Khatlon OHD premises (c) Furniture for 62 constructed / rehabilitated PHC facilities (e) Computers / printers and supplies for 59 constructed / rehabilitated PHC facilities (f) Medical, laboratory and cold chain equipment (g) Radio-communication equipment installed in 2 OHDs and 68 facilities in pilot rayons (h) 46 sanitary/ambulance

	supervision (l) Furniture for local inspectors (m) Engineer-estimators (2) (n) Oblast construction supervisors (3) (o) Facility designs, cost estimates, and supervision (p) Local (4) TA for feasibility study of radio-communication system in pilot rayons	vehicles, incl. spare parts (i) 42 diesel generators (j) Solar voltaic panels for 3 renovated PHC facilities (k) Methodology for needs-based selection of pilot rayons developed (l) Technical Norm for rural health facilities developed and adopted (m) 5 types of standard design packages for rural health facilities developed and adopted (n) PIU and MOH construction units' staff trained in-country and abroad
Sub-component C2. Strengthening PHC Services and Outreach (parallel financed by SIDA)	(a) Local (3) TA (MOH and oblasts-level) for coordination of MOH and partners in outreach activities (b) Outputs from the parallel financed SIDA project activities	(a) 14 coordination meetings with selected international NGOs conducted (b) 492 community organizations established; 331 of them prepared village development plans and implemented 1,065 projects; 12 community organizations received small grants in the total amount of 701,446 Somoni (c) 14 training programs developed (d) 118 health staff retrained at the Institute of Professional Re-training (e) 2,223 PHC staff and 30 staff of Centers of Healthy Lifestyle trained (f) Over 100,000 of population trained in relevant health topics (rational nutrition, safe delivery, breastfeeding, immunization, etc.) with involvement of over 2,000 health staff (g) 20,844 people referred to health facilities for preventive and curative services (h) 15,569 children covered under the Child Development Monitoring Program (i) 95,000 pupils trained in basics of hygiene by volunteer teachers

		(j) 1,078 volunteers selected, trained, and involved in the work with communities.
Sub-component C3. Strengthening PHC Training	(a) Minor civil works for renovation of FMTC (b) Medical literature for doctors and nurses (c) Teaching materials (d) Local (2) and intl (1) TA for Family Medicine training (e) Training of 270 doctors and 838 nurses in Family Medicine	(a) Soghd and Khatlon Oblast FMTCs renovated, incl. student dormitories, and equipped (b) 2 diesel generators for Soghd and Khatlon Oblast FMTCs (c) 10 FM trainers trained in Estonia and 2 nurse trainers in-country (d) 1,123 health staff (290 doctors, 833 nurses) trained in FM (e) 1,434 medical bags procured for retrained doctors and nurses (f) Libraries established in 2 Oblast FMTCs and RHCs of the 6 pilot rayons and supplied with medical literature (g) 1,058 re-trained health staff covered with CME courses (h) Teaching materials and training supplies provided (i) Training manuals developed by Republican and Soghd FMTCs printed and disseminated to FMTCs and all pilot PHC facilities: -Compilation of Clinical Practice Guidelines for PHC -Training manual "Antenatal Care for PHC" (j) 238 PHC staff trained in technical use, operation and maintenance of clinical equipment (k) Independent external evaluation of the quality of FM training conducted
Sub-component C4. Food Price Crisis Response	(a) Training for PHC staff on rational nutrition and correct growth monitoring (b) Nationwide rational nutrition education (c) Nationwide Vitamin A supplement to post-partum women (d) Iron and folic acid supplements for pregnant and lactating women in Soghd and Khatlon oblasts	(a) 2-day training module developed, 49 trainers and 433 PHC staff trained on rational nutrition, and 22 trainers and 845 PHC staff on correct growth monitoring (b) Beneficiary registration book and information booklet designed in Tajik

	(e) Growth monitoring equipment to 1,200 PHC centers in Soghd and Khatlon oblasts (f) Food packages for undernourished women receiving prenatal care, delivery, or vaccination in PHC centers in poorest rayons	language, printed and disseminated (1,200 books to RHCs and 50,000 booklets to beneficiary women, respectively) (c) 172,562 pregnant and breastfeeding women trained in rational nutrition, with 80% of them applying the acquired skills in practice (d) High-dose Vitamin A supplement provided to 50,000 post-partum mothers in Soghd and Khatlon oblasts (e) Iron and folic acid supplements provided to 50,000 pregnant and breastfeeding women in Soghd and Khatlon oblasts (f) Growth monitoring equipment provided to 1,195 PHC centers in Soghd and Khatlon oblasts, and 800,000 child development monitoring cards printed and disseminated to PHC facilities in the whole country (g) 150,000 food packages provided to 50,000 pregnant and breastfeeding women (3 times to each) in Soghd and Khatlon oblasts (h) Information campaigns conducted, incl. 350 minutes of airtime at national and oblast-level TV channels, 58 minutes in radio broadcasts, 32 articles in newspapers, and 21 articles on the Internet (i) Independent evaluation of effectiveness of Food Price Crisis Response interventions.
Component D. Project Coordination and Capacity Building for Implementation	(a) Vehicles for PIU (b) Office equipment, materials and supplies (c) PIU operating costs (d) Local TA (PIU staff, central and oblast-level) (e) Renovation of office at MOH for fiduciary unit	(a) 3 vehicles for PIU (b) Office equipment, materials and supplies (c) PIU operating costs (d) Local TA (16 core PIU staff, 28 MOH- and PIU-based and 35 oblast-based consultants)

	(f) Building capacity in financial management and procurement at MOH and in two oblasts (g) Building PIU capacity in project implementation and M&E (h) Annual external project audits	(e) Project Operational Manual developed in 2006 and updated in 2009 (f) Office at MOH for fiduciary unit renovated, computer network and server equipment installed (g) Building capacity in financial management and procurement at MOH and in two oblasts (h) Building PIU capacity in project implementation and M&E (i) Annual external project audits (j) 9 HMIS software skills training modules developed (k) 8 HMIS software skills trainers trained (l) Computer literacy training provided to 877 staff (PHC/hospital managers, accountants, statisticians, senior nurses of hospital admission desks) (m) Numerous presentations on project activities delivered to key stakeholders (n) Regular project monitoring visits to pilot rayons conducted (o) All required financial, implementation progress, and project management reporting submitted timely.

Annex 3. Economic and Financial Analysis

Cost-Benefit Analysis

1. Background

Tajikistan is the poorest of the former Soviet republics and even today is still recovering from armed conflict scars. Health outcomes are poor and the country increasingly faces a double burden of communicable and non-communicable diseases. Maternal and child health are a major challenge and the country is unlikely to meet the MDGs for infant and child mortality. After decades of neglect, the health infrastructure is dilapidated, and major investments are needed to retrain health workers on family medicine. Funding in the health sector is highly unequal and largely concentrated at the secondary and tertiary levels at the detriment of PHC. Limited managerial capacity in the health sector contributes to perpetuate inefficient financing practices.

To help overcome some of these key health sector challenges, the CBHP promoted the implementation of several activities that intended to (i) strengthen the national capacity for health policy, planning and donor coordination, (ii) implement organizational and financing reforms in the health sector and (iii) strengthen PHC in selected rayons.

At the time of the last ISR, almost all CBHP planned activities under the project had been completed. Some, but not all, of the PDO level indicators as well as the intermediate results indicators have been achieved. The health physical and human capital infrastructure has been strengthened, with a total of 68 buildings including 61 PHC facilities and 7 other buildings (oblast health departments, training centers, MOH premises, etc.) rehabilitated or replaced and 1,123 PHC personnel retrained in family medicine. A system of PHC capitation has been implemented in 44 districts and there are plans to further extend it nationally. A Health Policy and Analysis Unit (HPAU) has been established within the MOH to monitor and evaluate health reforms and provide policy advice in response to MOH needs.

This economic analysis intends to review the development impact of the CBHP in Tajikistan. In particular, the analysis aims to provide evidence on the project costs and benefits and, to the extent possible, estimate the cost-benefit of the investments that were done during the course of the project.

2. Methodology, data and assumptions

The project investments created both direct and indirect benefits for the population in project supported areas as well as for the public administration and the health system in general. The methodology used for assessing the direct and indirect benefits as well as the project costs are discussed in order below.

2.1. Direct benefits

The project benefits comprised several measures of direct impact, which included enhanced service quality at the primary care level through improved physical and human capital infrastructure. The project promoted improvements in the PHC infrastructure and a marked increase in the number of doctors and nurses trained in family medicine. 290 doctors and 833 nurses in 9 rayons had received training in family medicine in the project areas at closing. The resulting increase in service quality contributed to improved patient satisfaction, as

documented by a project impact evaluation report.[83] Although available data is somewhat mixed, the overall improved utilization of (mostly) PHC services in the pilot rayons suggests enhanced access to health services in those rayons. The improvements in service quality and personnel capacity led to significant increase in the number of visits to PHC facilities per capita per year in most project-supported areas. The change in the number of visits to PHC facilities per capita per year was estimated at 118% in Asht, 144% in Spitamen, -54% in Kabodiyon, 165% in Nurek, 76% in Sarband, -18% in Shuraabad, and 38% in Temurmalik.

It is likely that the increased utilization of primary care services led to subsequent reduced need for more expensive secondary and specialist care. Nevertheless, direct estimates of the impact on the utilization of secondary care level services of the increase in primary care visits are not available from direct project data. In line with impact estimates from other similar World Bank projects, we assume that total inpatient days from unnecessary hospital admissions were reduced by 30% as a result of enhanced utilization of outpatient care. Using estimates from the WHO-CHOICE database, the cost per inpatient day is estimated at about $5.7 and the cost per outpatient visit at around $1.3.

2.2. Indirect benefits

Indirect benefits were derived from improved process indicators such as increased implementation capacity of the MOH and other government bodies in addressing the needs of health sector. Similarly, there are indications that the project promoted enhanced donor coordination, which contributed to increase the amount of resources available to support the health sector, as evidenced for example by the sustained international support for the continuation of certain project activities. In addition, the introduction of capitation financing reforms is likely to have contributed to greater efficiency in the delivery of PHC services. More broadly, it is reasonable to expect that the project had significant indirect economic benefit on the wider economy. For instance, the increased access and utilization of health care services is expected to lead to improvements in health status. These, in turn, would reduce productivity losses, lower absenteeism, increase payoff periods and returns to investment in child health and, possibly, reduce future need for health care spending (an ounce of prevention is worth a pound of cure).

Nevertheless, no direct evidence is available to corroborate these hypotheses regarding the indirect impact of the CBHP. Therefore, in line with previous assessments of the economic impact of the project, the scope of this economic analysis will be limited to the areas where there is more readily available information.

2.3. Project costs

As discussed above, since we cannot reasonably estimate the economic benefit of all project activities, the economic analysis will be restricted to the Component C. The estimated total project costs for the original CBHP, AF1, AF2, and SIDA/SDC financing is shown below. Resources from the Global Food Price Crisis Response TF are not included in the analysis because these activities had a slightly different nature and the outcomes from the Food Grant can be considered time-limited.

Table A.1: Summary of project costs, original CBHP, AF1, AF2, and SIDA/SDC financing (Thous. US$)

[83] INTRAC & Dynamic Management (2010). Impact Assessment of the Community and Basic Health Project. Project Progress Report.

Year	Total	Component C
2006	1,587	579
2007	3,493	2,062
2008	7,657	4,937
2009	4,673	2,965
2010	6,030	2,767
2011	1,161	573
2012	2,167	1,737
Total	26,767	15,620

The total project cost was $26.77 million for the overall period out which of $15.62 million (58% of total) was used to support activities under Component C. The projected was implemented over a period of 7 years, with both the total annual investments and the annual investments in infrastructure (Component C) peaking in 2008.

3. Cost-benefit analysis and measures of economic efficiency

As noted in the Bank's Economic Analysis Guidance Note[84], not all project benefits can be expressed in monetary terms; indeed, some project benefits are often "difficult to monetize or even quantify but can be demonstrated to be important as project outcomes". In the case of the CBHP, the lack of available evidence limits the scope of the analysis than can be performed. Most of the available data refers to information on process or output indicators and there is limited information on outcome indicators to enable a quantitative analysis of the economic returns to investment. For example, the increased number of health workers and other health sector staff that received training (inputs) lead to significant improvements in the quantity and quality of services delivered (outputs). For instance, outpatient visits per capita increased by 70% on average in project areas. Still, it is unclear how these improvements translate into the impact on health outcomes and, ultimately, greater economic benefits. Therefore, in line with previous project papers, this analysis is limited to only a subset of the full spectrum of activities supported by the project, specifically those supported under Component C.

Table A.2: Measures of efficiency (3 percent discount rate)

	3 percent discount rate
Present value of project benefits (Thous.US$)	17,412
Present value of Component C cost (Thous.US$)	13,937
Present value of project net benefits (Thous.US$)	3,475
Benefit/Cost ratio	1.2
Economic rate of return	23%

The results of this economic analysis cannot be compared to the original economic analysis because the CBHP original PAD does not include an economic analysis. However, a subsequent project paper for additional financing conducted an economic analysis focused specifically on subcomponent C1 and estimated the internal rate of return at 9% for the first five years. The estimates provided here give a conservative estimation of the project benefits that does not take into account several measures of indirect impact and, in the absence of project-level evidence, assumes limited effectiveness of some of the main project activities.

[84] World Bank (2013). Investment Project Financing Economic Analysis Guidance Note. April 09, 2013.

Fiscal Sustainability Analysis

A fiscal sustainability analysis carried out as part of the PAD estimated recurrent expenditures for project investments and compared the total cost impact with projected increases in public health expenditure by the GOT. Total annual recurrent costs were estimated at US$1,085,000. As non-salary expenditures in PHC were projected to increase by US$1.4 million in 2006, it was concluded that the project investments were likely to be sustainable after completion.

In order to assess the fiscal sustainability of project investments after completion, this analysis was repeated using actual project costs to estimate the recurrent cost impact. Data on government health expenditures during the project period were provided by the MOH.

Only the parts of project components with a recurrent cost impact were included in the analysis; namely civil works, vehicles and equipment (medical, information technology and office). Salary costs associated with the continued functioning of the Health Policy Analysis Unit were excluded as either further funding was being provided by other project partners or functions were being absorbed by pre-existing MOH employees.

Assumptions for the analysis included the following (as per original analysis):

- Civil works
    - maintenance allowance of 2.5% of investment cost
    - an immediate need for full maintenance on new facilities
    - depreciation to zero over 50 years
- Vehicles
    - maintenance allowance of 10% of investment cost
    - depreciation to zero over 10 years
- Equipment
    - maintenance allowance of 5% of investment cost
    - depreciation to zero over 5 years for information technology equipment
    - depreciation to zero over 10 years for medical and office equipment

Table 3.1 displays the parts of project components with a recurrent cost impact. The annual recurrent expenditure of the project going forward was estimated to be US$1,081,615.

Table 3.1: Recurrent cost impact of project investments

Component	Actual cost in US$	Maintenance factor (%)	Maintenance allowance per year in US$	Depreciation factor	Depreciation cost per year	Annual recurrent expenditure in US$ (maintenance allowance + depreciation cost)
A1 Civil works	76,090	2.5	1,902	50	1,522	3,424
A1 Equipment (office)	156,364	5	7,818	10	15,636	23,455
B1 Equipment (IT)	98,930	5	4,947	5	19,786	24,733
B1 Vehicles	570,291	10	57,029	10	57,029	114,058
B2 Equipment (IT)	1,076,489	5	53,824	5	215,298	269,122
C1 Civil works	8,154,424	2.5	203,861	50	163,088	366,949
C1 Vehicles	782,188	10	78,219	10	78,219	156,438
C1 Equipment (IT)	134,758	5	6,738	5	26,952	33,690
C1 Equipment (medical)	598,312	5	29,916	10	59,831	89,747
TOTAL	**11,647,846**		**444,253**		**637,361**	**1,081,615**

Table 3.2 displays public health expenditures by the GOT during the project period. Public health expenditures as a percentage of GDP rose from 1.3% to 2% during the project period, with a 47% increase from 2010 to 2011. In particular, expenditure on PHC increased from US$7.1 million in 2007 to 32.4 million in 2011. In 2011, non-salary expenditures in PHC were US$4.9 million, five times the estimated annual recurrent cost expenditures.

Table 3.2: Government health spending in the Republic of Tajikistan, 2004-2011
GDP in USD from World Development Indicators

Indicators	*2004*	*2005*	*2006*	*2007*	*2008*	*2009*	*2010*	*2011*
GDP in somoni millions	5,100	7,201	8,400	9,550	14,800	20,200	24,500	30,180
GDP in USD million (constant 2000)	1261.0	1393.2	1175.0	1430.2	1734.0	1801.6	1918.7	2060.7
Health expenditures as % GDP	1.3%	1.2%	1.3%	1.9%	1.7%	1.9%	1.6%	2%
Annual % increase in health expenditures	57.5%	3.9%	58.8%	58.2%	43.3%	55%	4.4%	47%
Expenditures per capita (USD)	3.5	3.3	4.8	7.5	10.3	13.8	12.8	18.0
PHC total expenditures in USD millions	-	-	-	7.1	13.8	20.2	23.1	32.4
PHC salary expenditure in USD millions	**-**	**-**	**-**	6.0	11.7	17.2	19.6	27.5

PHC non-salary expenditures in USD millions	-	-	-	1.1	2.1	3.0	3.5	4.9

The recurrent project expenditures represent just over three percent of PHC expenditures for 2011 and just 0.08% of total public health expenditures. Furthermore, the economy of Tajikistan has increased six-fold over the past seven years. Given the significant increase in public health expenditures in Tajikistan over the last decade and the healthy economic outlook, the recurrent cost impact of this project is negligible and project investments are likely to be sustainable.

Annex 4. Bank Lending and Implementation Support/Supervision Processes

(a) Task Team members

Names	Title	Unit
Lending		
Saodat Bazarova	Operations Officer	ECSH2
Sarbani Chakraborty	Sr. Health Specialist	EASHH
Arsen Khadziev	ET Consultant	ECSHD
Peyvand Khaleghian	Country Sector Coordinator	ECSH2
Naushad A. Khan	Lead Procurement Specialist	SARPS
Aliya Kim	Finance Assistant	ECCKA
Andrew James Mackie	Consultant	PRMPS
Ross S. Pavis	Senior Operations Officer	ECSSD
Julie Wagshal	Quality Control Assistant	CFPMI
Supervision/ICR		
Anne Margreth Bakilana	Economist	ECSHD
Pia Helene Schneider	Sr. Economist	ECSHD
Norpulat Daniyarov	Financial Management Specialist	ECSO3
Dorothee B. Eckertz	Sr. Operations Officer	ECSH1
Gabriel C. Francis	Program Assistant	ECSHD
Elena E. Glinskaya	Country Sector Coordinator	ECSH3
Gulana Enar Hajiyeva	Environmental Specialist	ECSS3
Elena Karaban	Communications Officer	ECAEX
Dilshod Karimova	Procurement Analyst	ECSO2
Peyvand Khaleghian	Country Sector Coordinator	ECSH2
Naushad A. Khan	Lead Procurement Specialist	SARPS
Vladimir Kolchin	Economist	ECSP1
Rekha Menon	Senior Economist	ECSH1
Wezi Marianne Msisha	Health Specialist	ECSH1
Imelda Mueller	Operations Analyst	ECSH2
Shodi Nazarov	Financial Management Analyst	ECSO3
John Otieno Ogallo	Sr. Financial Management Specialist	ECSO3
Tamer Samah Rabie	Sr. Health Specialist	ECSH1
Fasliddin Rakhimov	Procurement Specialist	ECSO2
Shoira Zukhurova	Team Assistant	ECCTJ
Nagaraju Duthaluri	Lead Procurement Specialist	ECSO2
Sarvinoz Barfieva	Consultant	ECSH1
Lingzhi Xu	Sr. Operations Officer	ECSH1
Antonio Giuffrida	Sr. Economist	ECSH1
Ayshe Muratova	ET Temporary	ECCTJ

(b) Staff Time and Cost

Stage of Project Cycle	Staff Time and Cost (Bank Budget Only)	
	No. of staff weeks	USD Thousands (including travel and consultant costs)
Lending		
FY03	5.53	23.08
FY04	19.41	46.03
FY05	25.71	67.41
FY06	19.79	49.81
Total:	**70.44**	**186.33**
Supervision/ICR		
FY06	25.45	36.96
FY07	57.02	111.16
FY08	50.79	85.60
FY09	54.68	112.16
FY10	47.52	89.74
FY11	46.40	98.11
FY12	43.18	74.16
FY13	34.33	56.45
Total:	**359.37**	**664.34**

Annex 5. Beneficiary Survey Results

N/A

Annex 6. Stakeholder Workshop Report and Results

N/A

Annex 7. Summary of Borrower's ICR and/or Comments on Draft ICR

/ The Ministry of Health of the Republic of Tajikistan
Republic of Tajikistan, 734025, Dushanbe, 69 Shevchenko Str., Tel.: (+992 37) 2 21 18 35, Fax: (+992 37) 2 21 75 25 /

dated “ 28 ” 12 2012, No. *1 6/3263-3220.* Dushanbe

To: Saidov D.Sh.
Chairman of Committee for State Investment and
State Property Management of the Republic of Tajikistan

Copy to: Najmiddinov S.M.
Minister of Finance of the Republic of Tajikistan

Marsha Olive
World Bank Country Manager for the Republic of Tajikistan

Dear Davlatali Shomakhmadovich,

The Ministry of Health of the Republic of Tajikistan extends its gratitude to SCISPM for cooperation and continuous support in the settlement of issues regarding the implementation of investment projects in the health sector and presents for your appraisal a copy of the letter and the report of the CBHP PIU regarding the implementation of the item II of the Aide-Memoire dated December 13, 2012 of the CBHP mission, where it touches upon a number of tasks to be implemented at the final stage of the Community Based Health Project (Grant H586-TJ) till 31 December 2012.

It must be noted that in accordance with the information from the PIU Director, the form and way of reporting was discussed with the World Bank. The report had been sent to the Ministry of Health.

Respectfully,

Minister (signed) N. Salimov

1.0. Project initialization and project context at the evaluation stage

1.1. Historical context at the evaluation stage:

Political context: During the years following the collapse of the soviet system, Tajikistan endured the most severe political crisis civil conflict (1992-1997) resulting in multiple human losses among non-combatants, considerable destruction of the social infrastructure, including in the health sector, entire economic decline among former soviet republics, and destruction of the recently existing public management principles based on soviet system of the country management. Qualified staff outflow, need to rehabilitate post-conflict destructions, establishment and formation of new country management structures, formation of the new political forces and parties, creation of the nation-building legal framework were important political challenges faced at project onset.

Social and economic situation. Despite the impressive progress achieved in the last decade, Tajikistan is still the lowest income country in the world with estimated per capita GNI at US$200 in 2003. Tajikistan's population had fairly low health indicators among the CIS countries and its epidemiological situation is close to the countries with the lowest income in the world.

Main challenges in the health sector: The health system in Tajikistan has multiple structural weaknesses: PHC doesn't receive adequate attention; number of hospitals is greater than needed and their services are too expensive for the poor; health staff salaries are low and this forces them to take out-of-pocket payments for services; and development of HR capacity and health education are carried out insufficiently. There are major gaps in the Health strategy, especially in its planning and management at all levels and at the health facility administrations. Infrastructure is in very poor condition. Notwithstanding these problems, the Government of Tajikistan has agreed to carry out a range of budgetary and organizational reforms in the framework of the WB Loan for strategy development and implementation (LSDI) that will strengthen management and reinforce flow of funds towards to PHC. There is no well-defined management in the health policy in Tajikistan. In fact, concurrence on the common sector strategy is absent. the lack of internal dialogue among key parties – MOH, MOF and in particular, the Executive President's Office, results in the policy incoherence. It is reflected in donor activity that has been defined by weak coordination until recently.

Institutional environment: Project implementation was carried out by the Project Implementation Unit on the behalf of the MOH. For greater PIU integration with MOH and other partners and with the purpose to build internal MOH capacity for implementing projects and other appropriate responsibilities, the PIU has been moved closer to the MOHSIDASIDA.

1.2. Project components and subcomponents.

PROJECT GOALS AND OBJECTIVES. THE PRINCIPAL PROJECT OBJECTIVE IS STRENGTHENING OF THE MINISTRY OF HEALTH'S CAPACITY AND EFFECTIVENESS, IMPROVING HEALTH CARE MANAGEMENT AT THE NATIONAL, OBLAST AND RAYON LEVELS, AS WELL AS ENHANCING THE ACCESS, USE AND PATIENT SATISFACTION OF HEALTH SERVICES.

Project Summary:

CBHP was implemented oveer four years with a preparation period of twelve months. Primarily total project amount was US$17.3 million including contingencies. The project was financed with grant funds provided by IDA in the amount of US$10 million, US$6 million from the Swedish International Development Agency (SIDASIDA) and US$1.2 million from the Swiss Agency for Development and Cooperation (SDC). The project was implemented in two oblasts: Khatlon and Sughd according to administrative-territorial division of these oblasts apart from rayons where ADB operated; and six pilot rayons: Asht and Spitamen (Sughd Oblast), Shurobod, Kabodiyon, Nurek and Sarband (Khatlon Oblast) selected based on need; where the infrastructure of existing health facility network has been rehabilitated, staff has been trained on family medicine (physicians and nurses), was and community outreach was carried out.

2 Design, implementation and project impact

2.1. Assessment of the project design:

Design of this project, despite its fair ambitiousness, is optimal for achieving the stated goals; moreover project design has been elaborated in such a way that successful implementation of the scheduled activities and objective attainment required new levels of coordination among donor health sector community and intersectoral and subordinate public institutions, major international non-governmental organizations, public authorities at the national, oblast and rayon level, communities and mass media.

However, according to the independent final assessment, innovative design of this project was recognized as successful and became an important factor of the project goals achievement.

2.2. Principal outcomes, achieved objectives (i.e. on basic efficiency indicators **and under each component/ sub-component.**

Component A - Strengthening Policy, Planning and Donor Coordination in the Ministry of Health (MOH) – is aimed at strengthening MOH capacity through developing evidence based health policy, establishing Health Policy Analysis Unit (HPAU), supporting donor coordination and working groups engaged into development of the strategic conceptual documents of health system reforming, strengthening public relations, and executing health sector reforms.

Achievements:

1. **HPAU has been established according to the Decree of the MOH** No. 413 dated 14.07.07. HPAU has attained certain objectives, such as: conduction of three large-scale BBP introduction evaluations (HPAU support), a range of studies on per capita financing introduction, case-based payment system; involvement in development of the National Population Health Strategy until 2020, National Health Accounts, technical support when collecting information for developing the Health Facilities Master Plan; HPAU has collaborated with development partners in supporting the SWAp introduction, preparation for the Donor Community Steering Committees (SC) meetings, and participation in the international congresses with the scientific research outcomes etc.

2. **Established Working Group Secretariat** carried out organizational and informational support to the SC activity, specialized working groups and interagency organizations and is a liaison among operating various specialized working groups (over 44) providing them continuity and mutual awareness; 16 consultants have been hired to strengthen the capacity of MOH, and 168 MOH specialists and its departments receivedspecial training abroad.

3. **A Master Plan** for health facilities restructuring was developed. The Master Plan reflects long-term vision and objectives for achieving effective and sustainable growth in the health sector. The Strategic Plan on Health Facilities Rationalization in Tajikistan for 2011-2020 has been approved by the GOT Resolution No 169 dated April 1 2011; MOH has also approved Health HR Development Program of the Republic of Tajikistan for 2011 -2015, developed under the HPAU support.

4. **Support for conducting over 10 summits,** substantial number of round tables, SC meetings on transition issues to SWAp and donor community (DC) consolidation have been carried out and facilitated Availability of the specialized sub-divisions and officials engaged in donor coordination within the MOH organizational chart will create a basis for achieving donor coordination sustainability.

5. **Current MOH Press Center is operating.** Information on health reforms is disseminated via various channels, including website. TV broadcasting - 22997 minutes (for July 2012), radiobroadcasts - 9260, information on sites- 1152 and newspaper articles -368; and over 29 press conferences.

Conclusion under the Component A. It has been carried out transition from fragmentation in reforming facilitation to the strategic execution of implementation; created pre-requisites to the SWAp practical implementation and its application during the development of prioritized strategies of health sector and development of new coordination mechanisms; formulated demand for implementation of new effective methods of policy formulation based on facts; up-to-date methods of sector management: **problem prioritization – development of demanded efforts (planning) – financing rationale – accomplishment of the results;** transition made to the MOH leading position in management of donor assistance in health sector reforms; raised population awareness and generated confidence in the health sector reforms.

Component B Organizational and Financial reforms in the Health Sector (Subcomponent B-1; B-2; B-3). Support to introduce per capita financing and BBP in Sughd and Khatlon Oblasts through strengthening capacity of the health managerial and financial and economic units and MOH for controlling organizational and financial reforms.

Achievements:

Institutional MOH capacity was strengthened Per capita financing was introduced in all cities and rayons in Sughd and Khatlon Oblast (implemented in 41 rayons (2/3 of all country rayons):

BBP introduction progress: BBP facility contributes financial protection of the privileged category patients, attempts to ensure system transparency; primary health care status is strengthened, continuity between PHC and hospital services is ameliorated, BBP introduction system is positively perceived by health facilities and

population, public awareness on rights for free health care services was raised, number of pregnant women is increased who are registered by the maternity hospital and visit family doctor in order to get free delivery, informal payments made by population are legalized.

CBH Project has facilitated improvement and practical Basic Benefit Package implementation in the pilot rayons of the country as an actual advanced instrument of the financial health care services burden mitigation, in particular for the vulnerable population and legalization of the informal payments.

HMIS objectives accomplishment: (i) to train health facilities staff for HMIS component introduction through conducting staff training on computer literacy and ensuring health facilities have the required computer and office equipment; (ii) to develop information systems for planning PHC services and budget (business planning), financial tracking, monitoring scope of services rendered and morbidity control; and (iii) To adapt and introduce in the hospital facilities hospital HMIS developed by ZdravPlus for morbidity recording.

Results:

- **Supply of vehicles, computer and office equipment, Technical Assistance.** 1. Computer equipment in quantity of 679 kits were installed in 309 health facilities, the Ministry of Health, Sughd and Khatlon OHD, administrative units of the health departments in 41 rayons. Office furniture in quantity of 774 furniture sets was provided to 310 health facilities, the Ministry of Health, Sughd and Khatlon OHD, administrative units of the health departments in 41 rayons; PHC Managers in 41 rayons were provided with off-road vehicles; 47 sanitary vehicles were supplied to pilot rayons, 108 generators were procured and set up in the health facilities in 41 rayons.
- **Computer literacy training:** basic computer literacy training was conducted: 628 management staff in 41 rayons (Khatlon MPI - 318, Sughd MPI - 276, Local authorities - 34). Among 877 attendants, 63 were PHC Center Directors, 181 – rayon hospital chief doctors, 266 - accountants, 126 – medical statistics staff and 241 – senior nurses of the hospital admissions. Training for each group has been carried out using certain training module according to their terms of reference.

In the course of this project CBHP MHIS specialists have designed following programs:

- **ICD-10 Mini-handbook**, representing on-line version of the International Classification of Diseases of the 10th revision. **Business Plan software to collect data on provided health care services at the PHC facility level**
- “Stationar”: software program supporting data collection on hospitalization, co-payment and patient releases from the facilities of the secondary level
- “Buhgalter”: attachment, supporting accounting functions at the rayon level for consolidation financial data submitted by primary and secondary level facilities in the appropriate rayons. Training was conducted in the course of the common training courses.

Subcomponent C.1: PHC infrastructure strengthening

Achievements:

- **The methodology for the selection of the project covered rayons on the basis of extreme needs was developed**.

- **The document representing a structure and a set of technical standards is developed** that are recommended for the designing of health facilities, appropriate and effective in rural communities of Tajikistan standard design packages of rural health facilities are outlined, including additional packages to ensure the photovoltaic power, water supply, sewage disposal, the utilization and solid-waste recycling for health facilities to comply with a single primary care criteria for health facilities in rural communities of Tajikistan, as well as to adequately address environmental issues.

- **Conduction of monitoring**, In accordance with updated Environmental management Plan PIU has implemented following types of monitoring: (i) Monitoring before the construction to define main conditions as the impact of quality of voice, air and water, softening measures and cost of responding activities to the conditions In comply with local legislation and terms of ecological approval; (ii) Compliance Monitoring of Civic works; and (iii) Monitoring of Maintenance after the Construction. Every new project construction was accompanied by Checklists of (EMP) Environmental Management Plan, which has been an integral part of the contract for construction and installation works.

- **Rehabilitation and construction of medical facilities.**

Subcomponent C2. **PHC strengthening and enhancement of coverage** through coordination of dialogue among two communities, local authorities and health facilities in community and population health improvement mobilizing communities, prioritizing problems and micro planning of their solutions by community based organizations through small grants from ACTED, Mercy Corps and Aga-Khan Service on Health.

Achievements:

- **More than 5 meetings with implementing agencies were conducted including 9 coordinating working meetings with Health related NGOs**; Trainings, round tables were conducted within the communities; The main focus was made on cooperation with state structures, HLSC; The health workers and population within the project received additional information on ARI, breast-feeding, safe maternity, immunization, additional nutrition, HIV/Aids, malaria, preventive activities of communicable diseases, etc.

- **Communities have solved health problems independently.** Institutional structures of PO are being strengthened. Established **492** Public Organizations, 1129 general meetings are conducted with participation of health workers, 1078 volunteers are selected. About **500** public organizations are competent to conduct analysis (CCA) and do so with engagement of health workers. **904779 people** are trained in the pilot rayon communities. More than 2000 health staff are involved in the process of training.

- **More than 100 thousand people are covered by training,** referred to health facilities - **20844** patients., incl. for vaccination, weighing children, patients, pregnant women etc.

- **331** communities elaborated development plans of their settlements and implemented 1065 projects independently. Additionally, 12 community organizations for 50 projects received small grants for development in the amount of **701446 Somoni.**

- **Social structure is being formed on increase of responsibility in health protection** (Model: volunteer network – PO-PHC). More than **1078** volunteers jointly with health workers conduct training sessions with population.

Subcomponent C3: PHC Training Strengthening aimed at provision of equal access to population of 6 pilot rayons to more qualified Primary Healthcare**.**

Achievements:

- **Trainings of doctors and paramedical staff of pilot rayons in family medicine are completed** (so far 1,123 people graduated --290 doctors and 833 nurses--, which is 104% of the planned target);

- **Improved equal access of population** of about all pilot rayons to the qualified PHC services

- **The working conditions of re-trained specialists were bettered through** improved PHC infrastructure (rehabilitated and reconstructed health facilities, equipment with modern clinical and laboratory equipment, cold chain that enabled to increase of population access to the updated PHC services)

- **The interest of family doctors in trainings and betterment of their practices** were increased (in seminars within the Continuous Education program 1058 doctors and paramedical staff are covered), Essential increase of percentage of FM specialists (62%) accredited and received a category after the completion of re-training compared to those not taken re-training courses.

- **Improvement of access of health facility workers of pilot rayons to the modern medical books** (arrangement of libraries under RHC, consequently, possibility to increase their professional level)

- **In pilot rayons of Sughd Oblast the indicators of health staff working** as Family specialists indicates 92%% from the re-trained FM doctors and 97% from the re-trained Family Nurses, while in pilot rayons of Khatlon Oblast the indicators of health staff working as Family specialists indicates 70% from the re-trained FM doctors and 76% from the re-trained Family Nurses.

- **The independent evaluation of quality of FM specialists** in Training facilities of the country are conducted with involvement of international technical assistance, the results of evaluation and recommendations offered are adopted and approved by the Ministry of Health.

Subcomponent C4. Responding to the food crisis. The World Bank responded to the humanitarian crisis in the country by allocating additional financing for the **improvement of women and children nutritional status** through conduction of trainings on rational nutrition, delivery of food, micronutrients for pregnant and lactating women, infants and children as well as provision of PHC centers with stadiometer and scales.

Achievements:

- **The admission and early registration of pregnant women was increased**. Doctors believe that activities such as the distribution of food supplements to pregnant women, micronutrients and information materials is a good incentives for women to apply a doctor at early stage for registration of pregnancy and allows physicians to examine them and recovery if necessary.

- **80% of trained women** apply the knowledge gained into the practice, they use into their diet more fruits and vegetables, meat products (as far as possible). It is worth to notice that 62% out of re-trained women continue breast-feeding their children. 64,3% out of trained women who have children under 6 months continued breast-feeding while only 31,2% respondents not taken attended the trainings continued breast-feeding.
- **The widespread and proper use of growth monitoring equipment, consistent and correct account of anthropometric data.** Visit of 51 health facilities showed that the scales and stadiometers available are used and the results are fixed in the case-record book of a child.

- **Analysis of indicators by districts of Sughd region describes that t**here is a positive trend indicators such as: growing coverage of children (up to 134.3% in August 2009 compared to June 2009) that are measured height and weight, and assessed the development of the child according to the new standards; Increase the identification of children with malnutrition at 58.8%; Increase the percentage of children with malnutrition registered from 67.7% to 79.9%.

- **Sufficient level of public awareness through the media.** To inform the public about the rational nutrition and the project activities on subcomponent C 4 for the reporting period was implemented: at the national and regional TV broadcasting composed 350 minutes of air time and on the radio - 58 minutes. 32 publications were placed in newspapers, 21 informative articles were put sites. Analysis of the questionnaires of household survey showed that 61% of women received information about rational nutrition through television and radio broadcasts, in newspapers and publications.

Component D – Project Management. Project Implementation Unit has been established on the basis of the Resolution of the Government of Republic of Tajikistan dated March 11, 2000 # 99 and currently is functioning as CBHP Management. PIU activities are implemented based on Constitution of Republic of Tajikistan, general laws, regulations and rules of the country.

2.3. Lessons learned

- Needs to closely cooperate with many stakeholders during the implementation of the project, specifically multifaceted participation in organization and management of HPAU (CBHP, SIDA, WHO, MOH are involved), outreach activities (ACTED, Mercy Corps, Aga-Khan Fund) required substantial efforts on development of mechanism of joint activities, bid time expenditures to create a dialogue; And there were cases where the consensus was very hard to achieve.

- Well-coordinated team work of PIU jointly with MOH RT, Oblast Health Department of Sughd and Khatlon, as well as WB team during the whole period of implementation contributed to the better project facilitation in general.

- Capacity strengthening of CBH PIU specialists and staff, i.e. training while working may be also considered as important lesson in capacity strengthening for the country.

- Initial forecasts were not always realized as for rate of reform advance, especially financial reforms were considered adequate to implemented on grounds due to the influence of different out-of project factors (for instance, BBP implementation postponing at the level of pilot Oblast because of insufficient preparation of rayons, etc).

- The implementation of the project demonstrated that availability of prepared cadres on the grounds can create conditions for reforming at Primary level.

2.4. Project Impact to the reforming in health sector based on final evaluation of the project

The satisfaction of population with healthcare delivery is essentially higher in pilot rayons compared to the control rayons. It is characterized by the impact of all components of the projects**;** there is list of evidences available for it**.** However, for the further improvement of healthcare quality this sphere should remain prioritized.

Application of health services, especially at primary care level was increased and there is significant difference between pilot and control rayons. The larger increase in number and more medical and nursing references are observed in the pilot rayons compared to control ones, as a result of implementation of technical component (maintenance, equipment of facilities and staff), training (training of family specialists) and community-based components.

In general, "no admission" for healthcare has declined over the years to a sufficient extent, mainly by improving outpatient care. Residents of the pilot districts rarely postpone visits to a doctor, if it is necessary, compared to that of control rayons, respectively, 33.4% admissions compared to 36.4% in the control rayons.

The most common reason of "no admission" is financial lack to apply for services (80% of total responses).

The increase of health sector capacity at national, oblast and rayon levels in health and financial management as a result of the project implementation is obvious. The practice of conducting main researches is introduced which is supported by the project to get evidences during the health policy formation. Increase of capacity is also reflected in the use of computer technologies at all levels, maintenance of all techniques provided and equipments to solve the problems of patients and plans of a health facility (radio, transport, generators), informing the staff and using their business planning (Training).

3.0. Critical analysis of actions taken by the World Bank and the Government, and measures taken within the technical assistance

3.1 Efficiency evaluation of the World Bank during the project preparation and implementation

- Main solutions promoting the implementation of the project: Qualitative preparation of project proposals, tracing frequency of CBHP implementation progress, Support of efforts on MOH capacity strengthening, OHDs, focus on strengthening of analytical approach and enhancement of involvement rate state structures as one of the factors of post-project sustainability and reinforcement of cooperation of health sector of Tajikistan with Donor Community.

- Main decisions preventing the project implementation: any

- Assessment of activities of supervision mission of the WB: Recommendations of WB team on the results of systematic general missions reflected in aide memoir contributed to the timely implementation of measures and accomplishment of goals set within the project frameworks.

3.2. Evaluation of activities of Government during the preparation and implementation of the project:

3.2.1. Main decisions contributing to the project implementation:

- Well-timed and coordinated selection of pilot CBHP-covered rayons and Oblasts.
- Well-timed signing of agreements for execution of additional grants: (i) Financing agreement dated 22.05.09 (Grant №H461TJ); (ii) Financing Agreement dated 05.08.10 (Grant №H586TJ), (iii) Grant Agreement dated 17.07.08 from Trust fund on emergent Situations.
- Resolution of the Republic of Tajikistan No 169 dated 01.04.2011 «Strategic Plan of health facilities Rationalization of Republic of Tajikistan for the period of 2011-2020".
- Availability of relevant organizational and regulatory terms for CBHP implementation.

3.2.2. Main decisions (or lack of them) preventing the project implementation: any

3.2.3. Monitoring of MOH and PIU.

CBHP implementation has been accomplished based on data collection on fulfillment of tasks of the project component and subcomponents using quantitative efficiency indicators given in PAD and Operational Manual **with** logical relations to the expected results. The efficiency indicators are set in these documents per implementation years (monitoring indicators). Expected results per components and project in general suppose achievement of situation with many constituents undergoing different factors. That's why the indicators formulated are complex and include several subcomponents such as repair, equipment, and training. During the monitoring system building, the logic scheme and project implementation process itself was taken into account which consists of 4 stages: contribution, implementation process, results at the end and remote impact. The following constituents of monitoring and evaluation were identified as: (i) ***Monitoring and Evaluation instruments; (ii) Data collection methods and sources; (iii) Ways of checking the data provided; (iv) Reporting/Accountability system. Such data collection methods were used as monitoring cards, sampling from secondary sources, conduction of personal researches, working meetings, Steering sessions, fieldtrips with other donors, brief overviews/analytical notes, conduction of seminars, monitoring fieldtrip of profiled MOH working groups*** by subdivisions of MOH, Oblast Health Units.

As well as the regular instrument of monitoring and evaluation of project progress is **systematic semiannual general missions of WB team.** The main document upon the completion of mission - the aide memoir **is** presented to the Government of RT**,** National Committee on Investments and State Property Management**,** Ministry of Finance and Health, other stakeholders.

Systematic reporting/accountability, reports structure. PIU is preparing a report on Project Implementation status, where the monitoring indicators of all project components are reflected. Twice per year the efficiency indicators are updated, the report is developed on project management before the arrival of mission of WB specialists. Detailed Report on application of funds and dynamics of execution of planned measures, and brief information of project implementation progress is presented on monthly basis for coordinating and inspecting investment projects of State and MOH RT.

Project Evaluation. The **interim evaluation** was implemented. It did not change the design of the project: some formulations of table of indicators were made. To define the impact rate of community and basic health project on strengthening of capacity of MOH of RT, promotion of conditions and achievement of results of organizational and financial reforms of the sector as well as improvement of accessibility, quality and satisfaction with PHC services in 6 pilot rayons.

3.2.4. Adjustments made by the Government and its impact to the monitoring and project implementation:

CBH PIU director was changed due to the reaching of retirement age of former PIU Director; In accord with RT Legislation and adhering WB procedures a new director of PIU was appointed based on open competition, negative influence on the project implementation of administration change is not observed; The PIU activities are keep being evaluated positively in aide memoir.

3.3. Efficiency evaluation and quality of interaction of WB and Government in the course of Project Implementation is quite satisfactory.

3.4. Efficiency assessment of different organizations, companies and technical assistance during the project implementation (expenses compared to the benefits gained)

Conducted international and local technical assistances during the project implementation for the development of a number of major strategic documents, studies and surveys, as well as civil works, training and equipping of facilities were very useful in health care system that promote advancement of organizational and financial health reforms.

4.1. Project expenses: Forecasting expenditures at the evaluation stage against actual expenses by (i) components and subcomponents and by (ii) expenditure category and (iii) source of financing (equivalent in USD), if available. Grants amount allocated for the project implementation for all components and subcomponents as well as for categories and source of financing inclusive of supplementary inflows has been entirely disbursed. Amount of five grants (without C4 - food crisis grant) at the moment of the agreement signing composed **25.3 mln.USD**, and at the project completion it is **26.8 mln.USD**. Excess of the disbursed amount is based on the foreign exchange gain, received in the result of SDR and Swedish Krona fluctuations against USD during the project implementation period.

4.2. Operational annual expenses impacting the budget. Project design has specified the PHC strengthening by rehabilitating primary level facilities already available within the health structure and construction of the new ones, expenditures for which are incorporated in the budget; such additional expenditures related to purchased radio and communication equipment for the ambulance cars in 7 pilot rayons (annual payment for the radiofrequency, generators (fuel purchasing) were covered through financial support by local authorities.

4.3. Impact on institutional structure, established and supported by the project. Within the project there were established such institutional structures as HPAU in MOH structure and Press-Center; 60 sites are rehabilitated and constructed including RHC, RuHC, HH, Oblast TCCFM of Sughd and Khatlon. 4 more RuHCs will be constructed and equipped as well as a RHC of Temurmalik rayon will be rehabilitated due to the end of 2012. Re-trained FM specialists provided with medical wallets within the project are working in them. Training and re-training of FM specialists covered by the budget is planned to implement in Training Centers with active use of all subdivisions and structures: auditoriums, internet, presentation techniques, libraries, use of capacity of trained doctors.

5. Main lessons learned:

5.1. A number of important organizational and financial reforms of the health sector require coordination with many other agencies, as well as adoption of relevant Resolutions by the Government of RT (e.g.: BBP expansion across the pilot Region, Per-capita financing piloting with all types of expenses, etc.), which does not always correspond with the planned project activities.

5.2. Implementation of multi-component project, which essentially is complex program requires the formation of a competent team for the project fulfillment; it was the right decision project was implemented by PIU team, that had experience of execution of alike projects which are assessed as satisfactory.

5.3. Successful execution of multilevel and complex project the great role of which plays Ministry of Health of RT and its subdivisions, international non-governmental organizations, construction organizations, Training centers etc. demands development and introduction of new coordination mechanisms with all stakeholders using Sector Wide Approach.

5.4. Matters of further project sustainability should be resolved not at implementation or completion stage but at that of development of concept basis of project proposal as a certain strategy of project "exit" from the pilot areas.

5.5. Unorganized political environment, imperfection of structural building of co-subordination of health facilities at different levels of healthcare protection of population due to the numerous vertical programs, crudity of creation of Rayon health Departments and other aspects of organizational character were also crucial factor impacting project implementation progress.

6. Sustainability of project investments

It is worth to acknowledge the investments made sustainable as there are such aspects like: (i) establishment of HPAU, development of different strategic documents (ii) strengthening of infrastructure of MOH, OHDs of Sughd and Khatlon, TCCFM, PHC

facilities of pilot rayons, (iii) trained FM specialists,(iv) Promotion of AF at all 44 rayons of Sughd and Khatlon, and BPP in 3 pilot rayons with transition of functions on management of the issues to the trained specialists of pilot OHDs within the project. Hence, sustainability is achieved through the institutionalization, increase of skills and abilities of specialists involved, formation of responsible relations of communities to the healthcare, creation of regulatory basis, transition of functions and responsibilities to the relevant state structures and local authorities.

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dated "*05*" *06* 2013, No *1-6/2161-1436*. Dushanbe

Ms. Marsha Olive
Country Manager
World Bank Tajikistan Country Office
Republic of Tajikistan

Dear Ms. Marsha Olive!

The Ministry of Health of the Republic of Tajikistan would like to express its gratitude for the support and cooperation in the field of health reforms of the Republic of Tajikistan. At the same time, having studied the draft Community and Basic Health Project Implementation Completion and Results Report (IDA-H1950, IDA-H5860), the Ministry would like to present the following comments.

It is worth noting that the Implementing Agency for this Project is the Ministry of Health of the Republic of Tajikistan which implemented the Project through the Project Implementation Unit. Over the period of the Community and Basic Health Project implementation from 2005 through 2012, the health system has achieved certain progress which significantly influenced the quality of and access to health services in the pilot districts.

As such, the wording of the Project Development Objectives focuses on building capacity in administering the process of introduction of the Basic Benefit Package (BBP) and primary health care (PHC) financing reforms rather than enhancing efficiency of the BBP and financing reforms. In our case, the original Project design fairly assumed that the Project Development Objective should be namely strengthening capacity in managing the BBP introduction process and not BBP efficiency, as a probable long-term outcome, as such. Evidences of a significant progress achieved in BBP administration by the Ministry of Health are as follows:

- the Ministry of Health's leading role has been strengthened through the conduction of thematic health summits;
- clearer distribution of strategic areas under the financing reforms between the Development Partners (DPs);
- the Health Policy Analysis Unit (HPAU) has independently conducted a number of BBP surveys with elements of population interviewing;
- in-depth study by the Ministry of Health of the Sughd Oblast budget financing for potential risks of BBP extension to all districts of Sughd Oblast.

As far as the population's access to health services is concerned, it should be noted that 3 surveys have been conducted by independent survey firms under the assessment of financial burden of inpatient and outpatient services in the pilot districts after the introduction of the Basic Benefit Package. The results of these surveys showed that, compared with the control districts, the pilot districts had the level of informal payments reduced and the number of PHC visits increased, and introduction of the copayment scheme has improved the operation of health facilities.

It must be acknowledged that BBP has significantly strengthened the targeted access for the most vulnerable population; so, if approximately 30% of hospitalized patients belonged to the category of the supposed exempt population before the BBP introduction, this percentage has approached 60% already by 2012. One should note that a significant part of this cohort was represented by maternity patients, thus evidencing that the accessibility of in-patient obstetrics was ensured to some extent by BBP.

The Ministry of Health considers this a rather strong argument for the achievement of the indicators as this means that BBP introduction has played in general a positive role for the most vulnerable population in the pilot districts.

Regarding the strengthening of capacity in administering per-capita financing (PCF), the following positive aspects should also be noted:

— practically all districts of the country, including all the Project's pilot districts, use the PCF principle to calculate their budgets, and this mechanism has been solidly established at the national level (when the Project started, no districts used PCF);

— the adoption of a more reasonable approach to sector reforming, i.e. phased introduction of a new health financing mechanism (Decree of the Government of the Republic of Tajikistan No 536), provides an evidence of improved administration skills at the republican and oblast levels together with improved coordination with the Development Partners;

— joint Decree of the Ministries of Finance and Health (No 49-No 237 dated April 25, 2013) "On Introducing Full Per-capita Financing in PHC Facilities of Sughd Oblast from June 1, 2013" was signed. This provides an evidence that the practical implementation of full per-capita financing has started.

The change of the status of the indicator "100% per-capita financing in Spitamen rayon and 20% per-capita financing in the remaining 43 rayons of the two Project oblasts" from the PDO level indicator to the Intermediate Outcome indicator also bespeaks better per-capita financing administration by the Ministry of Health (the Tajik and English copies of the letters of the Ministry of Health and the Ministry of Finance are attached).

On the basis of the official data (reports of state supervision departments and services, the Health Policy Analysis Unit under the Ministry of Health), it is proposed to change the rating of the BBP administration capacity building indicators from *Moderately Unsatisfactory* into *Satisfactory*.

Also, we disagree with the Overall Outcome Rating assessed as *Moderately Unsatisfactory*.[85] The explanation of such a rating, which is mainly because of "the limited ability to substantiate the argument of increased access to health services in project-supported areas" (p. 27), is unpersuasive. As noted above, the results of the surveys conducted by the Health Policy Analysis Unit under the Ministry of Health under BBP (baseline survey, surveys conducted 3 and 15 months after BBP introduction) showed that the patients' satisfaction with the quality of health services provided to them has increased in the pilot districts after BBP introduction. The BBP introduction has slowed down the growth of the patients' financial burden. A significant decrease in the volumes of informal payments to the health staff is observed in the pilot districts compared with the control ones. BBP has contributed to the enhancement of transparency within the health financing system. It is worth noting that along with that, there are problems regarding full coverage of BBP by the state budget due to the increased number of health services provided to the exempt population. To address this issue, the Ministry of Health holds negotiations with the Ministry of Finance and other relevant agencies to increase the volume of health sector financing.

Given the above considerations, the Ministry of Health of the Republic of Tajikistan finds it acceptable to consider changing the outcome rating from *Moderately Unsatisfactory* to *Substantial*.

[85] The original draft that was sent for comments to Government had an MU rating. But then new data emerged on outcomes by Geographical area that confirmed more progress than initially described on health outcomes included in the project's results framework. This led to an upgrade in the rating.

The Ministry of Health of the Republic of Tajikistan avails itself of this opportunity to express once again its appreciation for the cooperation and support in the field of improving health of the population of our republic.

Sincerely yours,

Minister **/Signed/** **N. Salimov**

Annex 8. Comments of Cofinanciers and Other Partners/Stakeholders

In its e-mail of June 5, 2013, SIDA indicated that it had no further comments on the draft ICR and looked forward to receiving the final report.

SDC provided comments on the draft ICR by e-mail of June 13, 2013. Overall, SDC agreed with the overall outcome rating of the project as Moderately Satisfactory.[86] SDC confirmed that the ICR "thoroughly describes inputs and achievements of the project, sheds a light to the lessons learned and most importantly well describes the process of the project implementation. [SDC] appreciates that critical assessment of some project's activities, particularly related to health financing reforms, is done considering not only the challenging environment in which the project had to be implemented but also acknowledging the complexity of the project objectives which have been developed during the project's design without thorough estimation of risk factors. Though sustainability of the project's achievements and implementation of recommendations developed in strategic documents—Strategic Plan for Rationalization of Health Facilities of the Republic of Tajikistan for 2011-2020 and Program for Development of Human Resources in the Health Sector of the Republic of Tajikistan for 2011-2015—remains now with the Ministry of Health, the report will serve as an excellent reference document to follow up on the progress of health care reforms in Tajikistan.".

[86] The draft ICR was shared with SDC and SIDA for review and comments when additional survey data and information provided by the Ministry of Health had largely been reflected in the document and, as a result, the overall outcome rating upgraded to Moderately Satisfactory.

Annex 9. List of Supporting Documents

1. Analytical Report on Monitoring the Community and Basic Health Project, Association of Scientific and Technical Intelligentsia of Tajikistan, May 2012
2. Basic Benefits Package and Patient Financial Burden at the Hospital Level (Results After 15 Months of Implementation), HPAU MoHRT, September 2009
3. Borrower's Contribution to the Implementation Completion and Results Report, December 2012
4. Community and Basic Health Project (CBH project) - Component C, External Evaluation Final Draft, University Hospitals of Geneva, November 2010
5. Environmental Management Plan for the Tajikistan Community and Basic Health Project, Ministry of Health, October 2005
6. Final Completion Report for 2006-2012, Vol. I and II, Project Implementation Unit/Ministry of Health, December 2012
7. Hou, X., et al. (forthcoming, 2013). "The Health Sector and Economic Downturns: Learning from Failures". World Bank: Washington DC
8. Impact Assessment of the Community and Basic Health Project, INTRAC & Dynamic Management, September 2010
9. Impact of Migration and Remittances on Household Welfare and Poverty in Tajikistan, Tajikistan Statistics Agency, August 2010
10. Letter of Development Policy, Ministry of Health, September 2005
11. Project Implementation Report for 2006-2008 (Mid-Term Review), Project Implementation Unit/Ministry of Health, October 2008
12. Report, Konsultpro, October 2009
13. Tajikistan: Primary Data Collection on Capacity to Deliver Primary Health Care Services, Cooperation Agency for Health Care Services Development (ACODESS), November 2012
14. Vertical Functional Review of the Ministry of Health, Draft Interim Report, PDP Australia Pty Ltd, June 2010
15. World Bank, Aide Memoires and Back-to-Office Reports, 2004-2012
16. World Bank, Amendment to the Letter Agreement, Swiss Grant (TF090142) for Co-financing of the Tajikistan Community and Basic Health Project, April 2008
17. World Bank, Country Partnership Strategy for the Republic of Tajikistan for the period FY06-09 (Report No.32294-TJ), October 2005
18. World Bank, Country Partnership Strategy for the Republic of Tajikistan for the period FY10-13 (Report No.50769-TJ), April 2010
19. World Bank, Development Grant Agreement (H195 TJ), Community and Basic Health Project, February 2006
20. World Bank, Financing Agreement (H461 TJ), Additional Financing, May 2009
21. World Bank, Grant Agreement, Food Price Crisis Response Trust Fund (TF092349) Additional Financing, July 2008
22. World Bank, Implementation Completion and Results Report for the Primary Health Care Project (Report No.33634), September 2005
23. World Bank, Implementation Completion and Results Report for the Programmatic Development Policy Operations 1-3 (Report No.ICR00001279), March 2010
24. World Bank, Implementation Status and Results Reports (ISRs), 2006-2012
25. World Bank, Letter Agreement, SIDA Grant (TF056448) for the Co-financing of Community and Basic Health Project, April 2006
26. World Bank, Letter Agreement, Swiss Grant (TF057976) for Co-financing of the Tajikistan Community and Basic Health Project, April 2007
27. World Bank, management and other important letters and memoranda, 2004-2012
28. World Bank, Minutes of Decision Review Meeting, June 2005
29. World Bank, Minutes of Negotiations, Additional Financing, March 2009
30. World Bank, Minutes of Negotiations, Additional Financing, May 2010
31. World Bank, Minutes of Negotiations, Community and Basic Health Project, November 2005
32. World Bank, Minutes of PCN Review Meeting, February 2005

33. World Bank, Program Document for the Sixth Programmatic Development Policy Grant, September 30, 2012
34. World Bank, Project Appraisal Document for Tajikistan Community and Basic Health Project (Report No: 34080-TJ), November 2005
35. World Bank, Project Concept Note (PCN), January 2005
36. World Bank, Project Information Document, Additional Financing, May 2010
37. World Bank, Project Information Document, October 2005
38. World Bank, Project Paper (Report No.43839-TJ), Additional Financing, May 2008
39. World Bank, Project Paper (Report No.47561-TJ), Additional Financing, April 2009
40. World Bank, Project Paper (Report No.54208-TJ), Additional Financing, May 2010
41. World Bank, Republic of Tajikistan. Health Sector Note (Report No.29858-TJ), June 30, 2005
42. World Bank, Republic of Tajikistan. Poverty Assessment Update (Report No.30853-TJ), January 2005
43. World Bank, World Bank, Financing Agreement (H586 TJ), Additional Financing, August 2010

Annex 10. Activities Supported Under Additional Financing Grants (AF1 and AF2)

	AF1 Financing Gap	AF1 Scale Up	AF2 Scale Up
Component A: Strengthening Policy, Planning and Analysis			
A1: Policy Formulation and Analysis	• Surveys o Household Survey o Meta-analysis • Workshops / Seminars	• Develop/Institutionalize NHA • Local TA for HPAU	
A2: Strategic and Operational Planning		• Develop Health Sector Master Plan • Develop/implement Human Resource Rationalization Plan	Implement health strategies/policies, incl. HR rationalization plan and the business plan of the Master Plan, in at least one rayon.
A4: Public Relations and Communication	• Communication campaign to inform public about reforms		PR campaigns to inform population on health sector reforms.
Component B: Organizational and Financing Reforms in the Health Sector			
B1: Strengthening PHC Management and Financing B2: Strengthening Hospital Management and Implementing the Basic Program of Medical Care Services	Hospital management staff training on HMIS	• Scale up of capitation to all 41 rayons in two oblasts through additional investment in HMIS • IT assistance to OHDs, MOH and hospitals	Roll-out of capitation payment to all 44 rayons in two oblasts incl. capacity building and TA for oblast-level pooling, vertical scale-up of capitation payment to 100% of PHC expenditures in Spitamen rayon and 20% in the remaining rayons. Scale up BPMCS co-payment policy to all hospitals in Soghd oblast.
Component C: Strengthening PHC in Selected Rayons			
C1: Strengthening the PHC Infrastructure	• Provide radio communication systems, medical furniture and equipment • Outfit solar voltaic panels in renovated PHCs	• Repair of Soghd OHD premises • Renovate 2 PHC facilities • Local consultant for infrastructure	Reconstruct 7 PHC facilities on the same footprint in Nurek and Temur-Malik rayons. Provide basic medical equipment, sanitary vehicles, radio-communication systems, and medical furniture to new facilities.
C3: Strengthening PHC Training	Medical bags with medical material for staff attending FM training	Scale up FM training to staff of at least 2 additional rayons	Expand the ongoing FM model to three additional rayons (30 doctors and 222 nurses). CME for 280 doctors and 857 nurses, previously trained in FM. Train facility managers and provide management tools for health facilities in all 44 rayons in two oblasts.
Component D: Project Management			
	Continuous support to project implementation	Build fiduciary capacity in financial management and procurement at MOH and in two oblasts in accordance with recommendations of the Health Sector Fiduciary Capacity Assessment	Strengthen MOH's and PIU's capacity for M&E and project implementation, incl. audit, procurement, disbursement, and financial management activities

		Report Repair office at MOH to create space for fiduciary team	

Annex 11. Programmatic Development Policy Grants 1-6[87]

Medium-Term Objective	Improving public service delivery (Health)		
PDO Indicator	Wage bill for PHC workers rises faster than for other health care workers		
	PDPG1 (2006-2007)	**PDPG2 (2007-2008)**	**PDPG3 (2009)**
Policy Actions Specified	Adopt presidential decree that assigns greater share of wage bill increases in health to primary care in 2006	1. Adopt a government resolution that allocates in 2007 a greater share of wage increases in health sector to PHC, as agreed with IDA 2. Introduce through a government decree a calculation of co-payment categories and pricing for a guaranteed basic benefit package acceptable to IDA	1. Adopt a government resolution that allocates in 2008 a greater share of wage increases in health sector to PHC, as agreed with IDA 2. Expand per capita financing to additional seven pilot rayons by July 2008
Policy Actions Taken	An asymmetric wage increase in the health sector in 2006 has been introduced by a Presidential Decree with a greater emphasis on PHC workers' wages	A Decree of the Recipient's Government has been adopted to expand the PHC share of wage increases in health sector in 2007	Presidential Decree No.480 dated June 20, 2008 allocating a greater share of wage increases in the health sector to PHC workers has been adopted
Outcomes[88]	60% for PHC workers, 40% for others	54% for PHC workers, 46% for others	70% for PHC workers, 50% for others
Medium-Term Objective	**Protecting delivery of health services**		
	PDPG4 (2010-2011)	**PDPG5 (2011-2012)**	**PDPG6 (2012-2013)**
Policy Actions Specified	The Recipient has maintained in the 2010 budget an allocation for health care at no less than 2009 levels of 6.1% of the state budget as stated in the Budget Law No. 1456 dated November 11, 2009	The government adopts the health sector master plan consistent with the national health sector strategy	Utilization by 2 new districts of a per-capita formula in allocating 100% of PHC resources

[87] The table was developed based on the PDPG1-3 Implementation Completion and Results Report and PDPG1-6 Program Documents.
[88] The targets were not fully achieved, because funding to implement the asymmetric wage increases did not fully materialize

Policy Actions Taken and Outcomes	The Recipient has maintained in the 2010 budget an allocation for health care at no less than 2009 levels of 6.1% of the state budget, as stated in the Budget Law No.1456 dated November 11, 2009	The Recipient, through Government Resolution No.169 dated April 1, 2011, has adopted a health sector master plan consistent with the Recipient's National Health Sector Strategy	The Recipient, through Government Resolution No.536 dated November 2, 2011, has provided the basis for the introduction of a per-capita formula in allocating PHC resources in 2 new districts

TAJIKISTAN

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

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

Rayons

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

KAZAKHSTAN
UZBEKISTAN
KYRGYZ REP.
CHINA
AFGHANISTAN
PAKISTAN

SOGD REGION
KHATLON REGION
GHORNO-BADAKHSHAN A.O.
Region under direct Republic subordination

DUSHANBE
Khodjand
Chkolovsk
Taboshar
Konibodom
Ura-Tyube
Pendzhikent
Ayni
Jirgatal'
Rasht
Komsomolabad
Obigarm
Nurek
Kalaikhum
Vanj
Rukhch
Murgab
Rangkul'
Alichur
Khorog
Andarob
Vrang
Ishkashim
Kulyab
Kurgan-Tyube
Moskovskiy
Garavuti
Shahrtuz
Pyanj

Fergana Valley
Syr Darya
Kayrakkum Reservoir
Zeravshan
Trans Alai-Range
Pamirs
Panj
Vakhsh
Bartang
Murgab
Aksu
Pamir
Lake Karakul'
Lake Sarezskoye
Pik Lenin (7134 m)
Pik Imeni Ismail Samani (7495 m)
Pik Revolution (6,974 m)
Pik Karl Marx (6723 m)

To Tashkent
To Andijon
To Bukhoro
To Kyzyl-Kiya
To Sary-Tash
To Osh
To Qarshi
To Baghlan

68°E
70°E
72°E
74°E
40°N
38°N

0 20 40 60 80 Kilometers
0 20 40 60 Miles

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