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Report No: 47561-TJ

PROJECT PAPER

ON A

PROPOSED ADDITIONAL FINANCING GRANT AND
RESTRUCTURING

IN THE AMOUNT OF SDR 3.4 MILLION
(US$5.0 MILLION EQUIVALENT)

TO THE

REPUBLIC OF TAJIKISTAN

FOR THE

COMMUNITY AND BASIC HEALTH PROJECT

April 7, 2009

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

CURRENCY EQUIVALENTS

(Exchange Rate Effective February 28, 2009)

Currency Unit	=	Somoni
US$1.00	=	Somoni 3.5975
US$1.00	=	SDR1.47609

FISCAL YEAR

January 1 – December 31

ABBREVIATIONS AND ACRONYMS

AF	Additional Financing
ALOS	Average Length of Stay
ARP	Abbreviated Resettlement Plan
CAS	Country Assistance Strategy
CBHP	Community and Basic Health Project
CPS	Country Partnership Strategy
EMP	Environmental Management Plan
EU	European Union
GFPCR TF	Global Food Price Crisis Response Trust Fund
HMIS	Health Management Information System
HPAU	Health Policy and Analysis Unit
IDA	International Development Association
IFRs	Interim Un-audited Financial Reports
IRR	Internal Rate of Return
ISA	International Standards for Auditing
IT	Information Technology
MOH	Ministry of Health
NHA	National Health Accounts
NPV	Net Present Value
OHD	Oblast Health Department
PAD	Project Appraisal Document
PHC	Primary Health Care
PIU	Project Implementation Unit
PDO	Project Development Objective
SDC	Swiss Development Cooperation
SDR	Special Drawing Rights
SIDA	Swedish International Development Cooperation Agency
TF	Trust Fund
USAID	United States Agency for International Development

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PROJECT PAPER DATA SHEET

Date: April 7, 2009 Country: Republic of Tajikistan Project Name: Additional Financing and Restructuring for the Community and Basic Health Project Project ID: P115801	Team Leader: Pia Schneider Sector Manager: Abdo Yazbeck Country Director: Motoo Konishi Environmental Category: B
Borrower: Republic of Tajikistan Responsible agency: Ministry of Health	

Revised estimated disbursements (Bank FY/US$m)

FY	2010	2011			
Annual	1.8	3.2			
Cumulative	1.8	5.0			

Current closing date: March 31, 2010
Revised closing date: December 31, 2010

Does the restructured or scaled-up project require any exceptions from Bank policies?	○ Yes ● No
Have these been approved by Bank management?	○ Yes ○ No
Is approval for any policy exception sought from the Board?	○ Yes ● No

Revised project development objectives/outcomes

The original Project Development Objective will remain valid for the proposed Additional Financing, i.e. *to increase access to, utilization of, and patient satisfaction with health services in project-supported areas; and to build capacity and efficiency at national and oblast and rayon levels in administering the basic benefit package and per capita financing for primary health care.*

Progress towards the development objectives supported by the Additional Financing will be monitored according to the following key performance indicators:

- Share of health in household expenditure (overall and by household wealth quintiles)
- Number of visits per capita per year to PHC facilities
- Number of doctors and nurses trained in family medicine in the project area

Does the scaled-up or restructured project trigger any new safeguard policies? Yes

Safeguard Policies Triggered	Yes	No
Environmental Assessment (OP/BP 4.01)	X	
Natural Habitats (OP/BP 4.04)		X
Forests (OP/BP 4.36)		X
Pest Management (OP 4.09)		X
Physical Cultural Resources (OP/BP 4.11)		X
Indigenous Peoples (OP/BP 4.10)		X
Involuntary Resettlement (OP/BP 4.12)		X
Safety of Dams (OP/BP 4.37)		X
Projects on International Waterways (OP/BP 7.50)		X
Projects in Disputed Areas (OP/BP 7.60)		X

For Additional Financing			
[ ] Loan [ ] Credit [X] Grant For Loans/Credits/Grants: Total Bank financing (US$m.): SDR 3.4 million (US$5.0 million equivalent) Proposed terms: IDA Grant			
Financing Plan (US$m.)			
Source	**Local**	**Foreign**	**Total**
Borrower			
IDA	2.25	2.75	5.0
Others			
Total	2.25	2.75	5.0

Republic of Tajikistan: Additional Financing and Restructuring for the Community and Basic Health Project

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I. Introduction

1. This Project Paper seeks the approval of the Executive Directors to provide an Additional Financing Grant (AF) in the amount of SDR3.4 million (US$5 million equivalent) to the Tajikistan Community and Basic Health Project (CBHP) (Grant No. H-195-TJ). CBHP is co-financed by the Swedish International Development Cooperation Agency (SIDA); and the Swiss Development Confederation (SDC). CBHP has been very successful in supporting the initial reforms aimed at introducing capitation and output-based payment methods and improving quality of service delivery in Primary Health Care (PHC) centers. However, these reforms need to be sustained over time to deliver best results. The Bank is in a unique position to provide the support that is needed during the next phase of reform.

2. More specifically, the AF will finance (i) the completion of the CBHP investment, which would not be feasible otherwise due to the costs associated with higher than anticipated construction costs for health facilities; and (ii) the scale up of activities started under the CBHP to ensure their sustainability, and support the development and implementation of the health sector strategy. The AF is expected to finance a combination of consultant services, medical and computer equipment, medical furniture, basic renovation of an office in Oblast Health Department in Sughd, and training of health care staff in Family Medicine.

3. To harmonize the preparation of the Implementation Completion Report for the CBHP and the AF, the Closing Date of CBHP in the Development Grant Agreement will be extended from March 31, 2010 to coincide with the proposed Closing Date of the AF Grant of December 31, 2010.

4. The proposed AF includes a First Order Restructuring (Environmental Safeguard change) of CBHP (the Original Project) for the undisbursed portion of the CBHP pertaining to the construction of 11 PHC centers being built outside the original footprint and on new sites. While a Project-wide Environmental Management Plan was prepared for the Original Project an Environmental Assessment (OP 4.01) is triggered for the Additional Financing. The Environmental Category Rating for the Original Project is proposed to be upgraded from C to B. The Recipient will prepare site-specific Environmental Management Plans (EMP), in accordance with the Project-wide Environmental Management Plan, before the continuation of any further works on these 11 sites. An independent social assessment conducted on the due diligence of land acquisition for the 11 PHC centers concluded that no land acquisition or involuntary resettlement has occurred. Thus, OP 4.12 is not triggered in relation to the activities on these 11 construction sites.

5. The proposed AF is also given an Environmental Category Rating of B as **only limited renovation work within existing sites are planned.** OP4.12 is not triggered. No civil works for the AF will commence until Framework EMPs have been prepared, in accordance with the Project-wide EMP and OP 4.01 Environmental Assessment. The Project-wide EMP for the AF has been publicly disclosed on the Ministry of Health's (MOH) website on March 12, 2009, and its availability for public review and comments announced in local newspapers simultaneously. It has also been publicly disclosed through the Bank's Infoshop on March 12, 2009.

II. Background and Rationale for Additional Financing

Background

6. The CBHP was approved by the Bank's Board on December 15, 2005 and the Grant became effective on April 18, 2006. The Closing Date of CBHP is March 31, 2010. The Project Development Objective (PDO) is (a) to increase access to, utilization of, and patient satisfaction with health services in project-supported areas; and (b) to build capacity and efficiency at national and oblast and rayon levels in administering the basic benefit package and per capita financing for primary health care.

7. The CBHP consists of the following components: (A) Health Policy and Planning; (B) Organizational and Financing Reforms; (C) Strengthening Primary Health Care; and (D) Project Coordination and Capacity Building in Implementation.

Progress to Date

8. The PDO indicators reveal that satisfactory progress towards achieving the PDO has been sustained since project start. In particular, the project has been able to produce positive changes in the two pilot oblasts and to influence sector-wide reforms (in conjunction with the policy dialogue), especially on health financing and provider payment reforms which have focused on financial management training and delivery of computers to health facilities. Further, it has contributed to improved access to basic health care through substantial investment in PHC facility renovation and refurbishing, medical equipment and training of PHC staff. CBHP, in collaboration with other donors, has been supporting the MOH in developing a health sector strategy to guide future sector investment.

9. In June, 2008, the Bank's Board approved an Additional Grant for the CBHP to respond to the Global Food Price Crisis (GFPCR TF) in the amount of US$4.0 million, which was prepared in accordance with guidelines under O.P./B.P. 8.00 Rapid Response to Crises and Emergencies. Under the GFPCR TF, about 200,000 women who are pregnant or lactating are targeted for nutrition education and for micro-nutrients supplements (Vitamin A), iron and folic acid. Growth monitoring equipment is delivered to 1,200 PHC centers in the two CBHP oblasts. Women who are undernourished and visit a PHC center for prenatal care, delivery or child vaccination receive during each visit of these three visits a food package including 2kg of oil, sugar, rice and flour. After initial delays in the procurement of food packages and in the development of a satisfactory distribution plan, all goods have now arrived in the two oblasts. Food packages and nutritional supplements are being delivered to pregnant women living in lower-income areas, and growth monitoring equipments are installed in PHC centers. As of March 19, 2009 the total disbursement for this GFPCR was 34% covering nutritional supplements and delivery of nutritional education training to health professionals. The GFPCR will be fully implemented and disbursed by July 2009. An independent research team has been hired to monitor and evaluate the effectiveness of the GFPCR.

10. Project implementation proceeded quickly, and actual disbursements have consistently progressed above the originally anticipated levels of disbursement. As of March 19, 2009, the total disbursement rate for the original CBHP project is 76% of the grant, and 68% including the AF under the GFRCR TF (see Table 1).

Table 1: Disbursement, March 19, 2009 (in US$ millions)

	IDA CBHP	SIDA CBHP	SDC CBHP	TOTAL CBHP	AF-GFPCR TF092348	TOTAL CBHP+AF
Original Grant	10.00	6.11	1.18	**17.29**	4.00	21.29
As of March 19, 2009						
Contracted Amount	10.29	5.69	1.18	**17.16**	4.00	21.16
Disbursed	8.17	4.05	0.854	**13.07**	1.30	13.87
% Disbursed	79%	71 %	73%	**76%**	34%	68%
Current Undisbursed	2.13	1.64	0.32	**4.09**	2.70	6.67

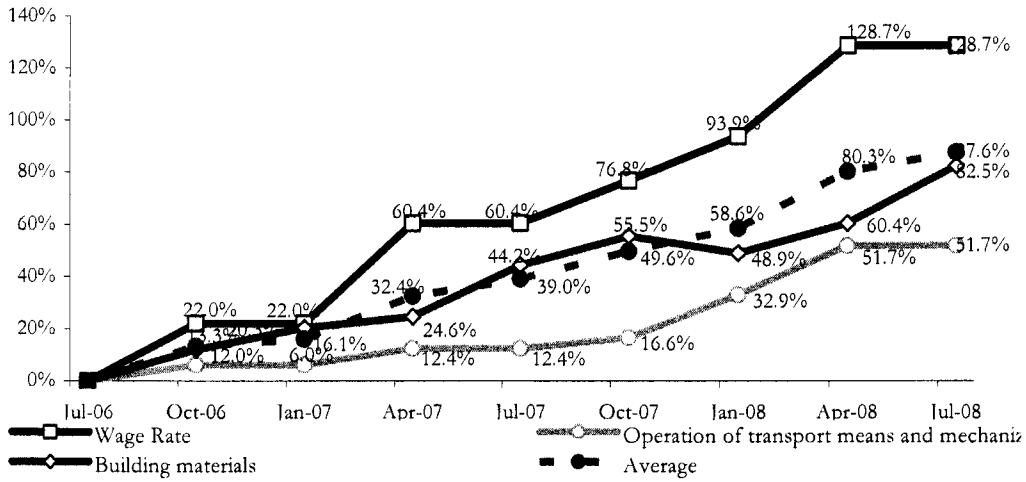
Justification for Additional Financing

11. The reasons for AF are two-fold, first to enable the completion of the original CBHP investments and activities, and second, to scale up and expand activities to maximize the development impact of the CBHP and support the development and the implementation of the health sector strategy. The CBHP is facing a financing gap, which was caused by an 87% increase in construction costs from 2006 to 2008, predominantly driven by higher wages and a price hike for building materials (Table 2 and Figure 1); and higher than originally anticipated operational costs. The financing shortfall has resulted in fewer rehabilitated facilities (55 vis-à-vis original target of 70), limited the provision of medical furniture, equipment and IT resources, and training of staff.

Table 2: Price increases in the costs of construction, 2006 – 2008 (in Somoni)

№	Building Resources	Unit of measurement	Price % of appreciation against July 2006		
			Jul-06	Jul-07	Jul-08
1	**Wage Rate**			**60.4%**	**128.7%**
1.1	Cost of 1 hour of wage of the worker of 4-th grade	1 hour	1.64c.	2.63c. 60.4%	3.75c. 128.7%
2	**Operation of transport means and mechanizms**			**12.4%**	**51.7%**
2.1	Dredgers (excavators)	1 hour	55.10c.	61.96c. 12.5%	98.31c. 78.4%
2.2	Cranes	1 hour	67.50c.	75.89c. 12.4%	95.09c. 40.9%
2.3	Vehicles	1 hour	37.10c.	41.68c. 12.3%	50.41c. 35.9%
3	**Building materials**			**44.2%**	**82.5%**
3.1	Woods	M^3	592.00c.	930.00c. 57.1%	1,054.00c. 78.0%
3.2	Rolled metal products	1 ton	2,277.00c.	2,885.00c. 26.7%	2,960.00c. 30.0%
3.3	Reinforcement	1 ton	2,240.00c.	2,800.00c. 25.0%	4,543.00c. 102.8%
3.4	Concrete	M^3	222.40c.	297.60c. 33.8%	435.64c. 95.9%
3.5	Cement	1 ton	350.00c.	625.00c. 78.6%	720.00c. 105.7%
% of average appreciation per year				**39.0%**	**87.6%**

Figure 1: Diagram of price increase of essential building resources



Source: FTI PMU August 2008

12. In addition to financing some activities for which there were no funds left under the CBHP, the AF will enable the Government to scale up existing efforts to improve efficiency, utilization and quality of PHC by supporting the implementation of sector and provider payment reforms in the two pilot oblasts. The AF will complement the capitation and hospital payment reforms that are being financed by USAID. This requires additional investments to modernize health and financial information technologies, to strengthen management capacity at different levels in the health system (such as the oblast and rayon health management department, the MOH and facility managers), as well as, to train medical staff to continue improving quality of health care and prevent drawbacks that the new payment system could induce. The development of the health sector strategy has only just started and needs to be sustained by developing and implementing related sub-strategies (e.g. Health Sector Masterplan, and Human Resource Rationalization Plan) to improve the productivity in the delivery of care; and by institutionalizing National Health Accounts (NHA) to monitor and evaluate the flow of funds in the sector. These investments will contribute to improving transparency, accountability and efficiency in the management of public funds in the health sector.

13. The proposed AF is consistent with the World Bank Guidelines for Additional Financing (OB/BP 13.20) as it will finance the "implementation of additional or expanded activities that scale up a project's impact and development effectiveness". The team has considered several possible approaches for financing the needed investments. The choice of AF was made to ensure prompt allocation of the required funds to guarantee successful implementation and completion of originally planned project activities; to maximize cost-effectiveness and timeliness in processing so that implementation of scaling up activities can benefit from existing implementation capacity and arrangements; and to contribute towards better implementation readiness for the Health Sector Strategy Project (P107790) currently under preparation, which is expected to be presented to the Board in September 2009.

III. Proposed Changes

Activities to be funded under the Additional Financing

14. The original PDO would remain unchanged. The AF will fund the financing gap under CBHP and scale up activities that were supported by the original project, as detailed in Table 3:

Table 3: Activities to be financed under the Additional Grant

	Financing gap	Scale up
Component A: Strengthening Policy, Planning and Analysis		

A.1 Policy Formulation and Analysis	• Surveys:
	  o Household survey
	  o Meta-analysis
	• Workshops / Seminars
		• Development and institutionalization of NHA
		• Local consultants Health Policy Analysis Unit (HPAU)

A.2 Strategic and Operational Planning		• Development of a Health Sector Masterplan in order to rationalize hospital overcapacity • Development and implementation of Human Resource Rationalization Plan to correct misallocation of staff
A.4 Public Relations and Communication	• Communication campaign to inform public about reforms	
Component B: Organizational and Financing Reforms in the Health Sector		
B.1 Strengthen PHC management and financing B.2 Strengthen Hospital Management	• Hospital management staff training on Health Management Information System (HMIS)	• Scale up of capitation to all 41 rayons in two oblasts through additional investment in HMIS • IT assistance to Oblast Health Department, MOH and hospitals
Component C: Strengthening PHC in Selected Rayons		
C.1 PHC Infrastructure	• Provision of radio communications systems, medical furniture and equipment • Outfitting of solar voltaic panels in renovated PHCs	• Repair of Sughd oblast Health Department premises • Renovation of 2 PHC facilities • Local consultant for infrastructure
C.2 PHC Training	• Medical bags with medical material provided to staff attending family medicine training	• Scale up family medicine training to staff of at least two additional rayons
Component D: Project Management		
	• Continuous support to Project Implementation	• Build fiduciary capacity in financial management and procurement at the MOH and in two oblasts in accordance with recommendations of the Health Fiduciary Assessment Report • Repair of office at MOH to create space for fiduciary team

15. The following Table 4 on the project costs and financing plan compares components under the project at appraisal, the additional GFPCR TF added in 2008, and the sub-components planned under the proposed AF:

Table 4: Project Costs and Financing Plan (in US$ millions)

Component		CBHP At Appraisal	GFPCR	CBHP AF Proposed	TOTALS
A.	Strengthening Policy, Planning & Donor Coordination	1.58		1.06	2.64
B.	Implementing Organizational and Financing Reforms	4.68		0.68	5.37
C1-2.	Primary Health Care Infrastructure and Training in Selected Rayons	8.78		2.20	10.98
C3-5	AF under the Emergency Global Food Price Crisis Response TF		4.00		
D.	Project Management Fiduciary Capacity Building at MOH	0.66		0.23 0.83	0.89 0.83
	PPF Facility	0.30		0	0.30
	TOTAL	**16.00**	**4.00**	**5.00**	**25.00**
	IDA Share	**10.00**	**4.00**	**5.00**	**19.00**
	SIDA co-financing	**6.00**			

Institutional and Fiduciary Arrangements

16. Project implementation arrangements, which have been effective, would remain the same under the proposed AF. IDA funds provided under the AF arrangement will leverage use of the country's existing implementation capacity and utilize existing implementation arrangements for the CBHP. With procurement and financial management capacity becoming stronger at the MOH, the fiduciary responsibility for selected items will be transferred to the MOH staff, with guidance from consultants and the Project Implementation Unit (PIU), which is currently assisting the implementation of the CBHP.

IV. Consistency with CAS or CPS

17. The CBHP and the proposed AF remain consistent with and will contribute to the implementation of the Country Partnership Strategy for the period FY06-FY09 by helping to lay the foundation for future growth by preserving and enhancing human capital. By focusing on provider payment reforms in Primary Health Care (PHC) centers and hospitals, the AF will complement activities that are being financed by USAID, the SDC and the European Union (EU).

V. Economic Analysis of Financing Gap

18. The economic analysis was conducted only for the subcomponent C.1 (strengthen primary health care infrastructure) in the amount of US$1.5 million. The monetary benefits of this

subcomponent can be estimated. The investment is economically justified as it is expected to increase the utilization rate for PHC, lead to early detection and prevention of diseases and consequently lower the death rate. The AF will be spent to purchase radio and communication equipment, solar voltaic panels, medical furniture, repair and maintenance, and operating costs for central rayon hospitals, rural health care centers, and health houses in Soghd and Khatlon oblasts. Radio communication will lead to quicker availability of medical services and support emergency care provided by rural health care facilities; solar voltaic panels will improve heating and medical furniture will enable rural health care facilities to operate fully in delivering basic care (such as maternity care) at the facilities. The expected net benefits include income gained from lives saved and from a reduction in transport cost as rural population will not have to travel to central rayon or oblast hospitals. The net present value (NPV) of the investment using a 10% discount rate is positive after 5 years and the internal rate of return (IRR) is 9% for the first five years. The original CBHP does not include an economic analysis but only a fiscal sustainability analysis of the investment. Thus, the results of the economic analysis for this investment cannot be compared to the original economic analysis.

	5 years	6 years	10 years	20 years
NPV of Investment using 10% discount rate (Million of US$)	-$0.04	$0.31	$1.66	$4.45
Internal Rate of Return (IRR)	9%	17%	31%	35%

VI. Appraisal of Restructured or Scaled-up Project Activities

Technical

19. The planned activities build on experience accumulated during the implementation of the original project; support the development and implementation of the health sector strategy; and are in line with reforms currently being implemented in other Central Asian countries. In particular, investments in health sector sub-strategies and the NHA are expected to support the implementation of the health sector strategy currently being developed by the Government with donor support. Training in family medicine is planned to be scaled up to 2 additional districts; and the scale-up of capitation payment reforms will be supported to cover all 41 rayons in the 2 pilot oblasts. Moreover, international technical assistance will provide guidance on the investment in the health management information system to assess production of services in PHC. At the same time, the successful experience with hospital payment reform in 10 pilot rayons will be continued under the AF, and scaled up in Khathlon oblast in close collaboration with USAID.

Economic

20. Government intervention is justified to correct for the current adverse incentives set by the current provider payment system. PHC centers and hospitals are currently financed according to the inputs they use, and therefore, have no financial incentives to reduce the number of staff and beds, to increase the number of patients treated, and reduce patients' average length of stay (ALOS) in hospitals. As described in Section II above, the activities planned under the AF would continue to support the Government in developing and implementing provider payment reforms as the main strategy to improve efficiency of service delivery, control the cost of health care provision while ensuring access to quality care. Where implemented successfully, similar provider payment reforms produced a significant increase in productivity. Production of health care services, as measured by total hospital discharges, increased markedly in countries with

output-based payments, while it remained on a similar low level in Central Europe, where physicians are paid a monthly salary independent of their workload. Based on these experiences, the expectation is that, once the payment reform is completed, the number of hospital beds and the ALOS will decrease whereas hospital admission will increase resulting in increased productivity and better access. These payment reforms will be supported by the Health Sector Masterplan, a Human Resource Rationalization Plan, training of staff in family medicine and investment in medical equipment and the provision of other goods to improve the quality of services in PHC.

Environmental Safeguard Change (First Order Restructuring)

21. While a Project-wide Environmental Management Plan was prepared for the Original Project an Environmental Assessment (OP 4.01) is triggered for the Additional Financing. A change in the project environmental safeguard rating is proposed under the CBHP, from Category C to B for the construction of 11 PHC centers. The Safeguards section and Annex 10 of the CBHP Project Appraisal Document (PAD) stipulate that "civil works are to be limited to rehabilitation of small PHC facilities, but that it is conceivable that facilities might need to be replaced within the existing building footprint." An Environmental Safeguards Rating of C was given to CBHP. At the start of the CBHP, an EMP was prepared and publicly disclosed. During the project, 36 PHC centers underwent construction work, including 9 PHC centers which were renovated within the existing building footprint, and 16 PHC centers which included renovation outside the previous building footprint, but within the same gated/fenced compound and did not require new land acquisition.

22. With respect to the 11 PHC centers, these needed to be constructed outside the original footprint as well as on new sites because the old PHC centers were located in rented premises of other facilities (schools, utility rooms, etc) that needed to be vacated. In addition, according to the Masterplan for PHC, these 11 centers needed to be located at different sites to improve access to health care for the population. The 11 new sites were previously approved by the local authorities in compliance with the Oblast Development Plans, an environmental evaluation and in accordance with the legislation of the Republic of Tajikistan. According to the local authorities, no resettlement took place, construction was on territory that has not been populated before, was free of settlement, greenery or buildings and any economic activity. The land for these 11 new sites was allocated by the Decision of the Khukumats of the Rayons, based on four legal documents: (i) the Resolution of the Sate Sanitary and Epidemiological Supervision Center of the MOH; (ii) Proposal of the Environmental Protection Committee; (iii) Resolution of the Service for State Control over Environmental Projection and Management; and (iv) Siting Acts. While no land acquisition is necessary, the environmental safeguards rating needs to be changed from C to B to reflect the fact that these 11 PHC facilities are being built outside the original footprint. The upgrading to a B rating includes a revision of the EMP which needs to be in line with current Safeguards policies for a B-rated project. The site-specific EMPs are in the process of being completed and once they are approved by the Bank, construction of the 11 PHCs can resume. The revised Framework EMP in line with the B rating has been publicly disclosed on March 12, 2009.

23. In addition, an independent analysis (social screening) has been conducted on the 11 PHC facilities and confirmed that no land acquisition involving resettlement (physical or economic displacement) took place in association with initiating the construction of the above-referenced 11 PHC facilities. Therefore, no Resettlement Action Plan (Abbreviated Resettlement Plan or "ARP") is needed and OP 4.12 is not triggered.

Fiduciary

Procurement

24. Procurement for the AF will be carried out in accordance with the World Bank's "Guidelines: Procurement under IBRD Loans and IDA Credits" published by the Bank in May 2004 and revised in October 2006; and "Guidelines: Selection and Employment of Consultants by World Bank Borrowers" published by the Bank in May 2004 and revised in October 2006, and the provisions stipulated in the Grant Agreement. As a new commitment, the AF will be subject to the anticorruption guidelines and sanction regime; contracts must be financed either wholly from the original CBHP funds or from the AF funds so that they are traceable.

Financial Management

25. The financial management responsibilities for the AF will remain with the PIU within the Ministry of Health. The last supervision of the ongoing CBHP was conducted in October 2008. The financial management arrangements of the project were assessed to be satisfactory.

26. The audit of project financial statements for 2008 for the CBHP has been submitted on time and the audit opinion was clean. Quarterly financial monitoring reports are submitted timely and provide reliable financial information. The PIU is adequately staffed and appropriate controls and procedures have been instituted.

27. Auditing and financial reporting arrangements will remain the same for the AF. The financial statements will be audited by independent auditors acceptable to the Bank and on terms of reference acceptable to the Bank. The annual audited statements and audit report will be provided to the Bank within six months of the end of each fiscal year and at the closing of the project. The audits will be conducted in accordance with International Standards on Auditing (ISA). Project management-oriented interim un-audited financial reports (IFRs) will be used for project monitoring and supervision. The format of the IFRs used for the ongoing project will be also used for the AF. The PIU will produce a full set of IFRs for each calendar quarter throughout the life of the project for all project components and all sources of funding. They will be due 45 days after each quarter end. Disbursement Arrangements will continue to be the same for the AF. A Designated Account in US$ for administering the AF will be opened in a commercial bank acceptable to the World Bank. The ceiling for the Designated Account and other disbursement details are provided in the Disbursement Letter.

VII. Expected Outcomes

28. The PDO will remain the same, i.e. (a) to increase access to, utilization of, and patient satisfaction with health services in project-supported areas; and (b) to build capacity and efficiency at national and oblast and rayon levels in administering the basic benefit package and per capita financing for primary health care. In particular, it is expected that the activities financed by the AF will contribute to a more transparent and better managed PHC system that is able to use public and private resources allocated for health care more efficiently and delivers better access and quality services. In addition, human capital will be built in the health sector including fiduciary capacity at the MOH, and better skills in family medicine and health facility management in PHC centers. Progress towards the development objectives supported by the AF will be monitored using the same key performance indicators as under CBHP:

(i) Share of health in household expenditure (overall and by household wealth quintiles)
(ii) Number of visits per capita per year to PHC facilities

(iii) Number of doctors and nurses trained in family medicine in the project area

29. The expected intermediate outcomes of each component will be measured by the following **additional indicators**:

30. **Component A – Health Policy and Planning at the MOH**: to finance training, local and international technical assistance, workshops/seminars, study tours and minor civil works to help strengthen coherence and coordination in policymaking, policy analysis and the management of donor support by MOH.

- MOH completes one year of NHA (baseline: No NHA; target: NHA for 2008 and 2009 finalized and presented)
- MOH completes the Health Sector Masterplan (baseline: No masterplan; target: Masterplan finalized and presented to Government)
- MOH completes the Human Resource Rationalization Plan with implementation plan (baseline: No HR plan; target: HR plan finalized and presented to Government)

31. **Component B – Organizational and Financing Reforms in Health Sector:** to finance training, local and international technical assistance, workshops/seminars and study tours to help support the implementation of capitation financing for PHC and implementation of the Basic Benefit Package for hospital care.

- Capitation payment implemented for PHC (baseline 2009: 10 rayons; target: 41 rayons)

32. **Component C – Strengthening Primary Health Care**: to finance local technical assistance, training, medical equipment and civil works to help renew the PHC infrastructure in two to four rayons in Sughd and Khatlon oblasts and support complementary measures to improve service delivery and outreach, including training for health workers.

- Family medicine training expanded to 2 more rayons (baseline 2009: 0 staff trained in 2 additional rayons; target: 184 staff trained in 2 additional rayons)
- PHC centers equipped with communication system (baseline: 0 PHC centers; target: 26 PHC centers in 6 rayons)

33. **Component D – Project Coordination and Capacity Building for Implementation:** to build fiduciary capacity at the MOH.

- MOH completes implementation of Phase 1 Action Plan (see Fiduciary Capacity Assessment for the Health Sector).

VIII. Benefits and Risks

34. The main expected benefits are related to the modernization of the health infrastructure, medical and information equipment, the human capital building and the provider payment reforms in Tajikistan that the AF will support. They include: (i) a transparent health information system that is able to measure types, volume and quality of health care services produced; (ii) health institutions that plan, finance and monitor resources based on services delivered by providers instead of on inputs; and (iii) health services of better quality.

35. The main risk is related to the political instability in the country. A different political leadership for the health sector may need some time to become acquainted with the reforms that have happened in the past and are planned in the additional grant. There is, however, sufficient understanding and ownership of the activities planned in the MOH, the MOF and in health facilities themselves to expect that any eventual slow-down in reforms will not last too long.

IX. Financial Terms and Conditions For The Additional Financing

36. The proposed AF will be an IDA grant.

Annex 1: Indicators

Indicators	Baseline	Target 12/31/2009	Target 12/31/2010
Key performance indicators (same as original CBHP)			
Share of health in household expenditure (overall and by household wealth quintiles) measured Pre/Post Project	*Tbc* based on LSMS 2007		6%
Number of visits per capita per year to PHC facilities	4 (2008)		5
Number of doctors and nurses trained in family medicine in the project area	183 doctors and 453 nurses (Oct. 2009)		257 Doctors & 573 Nurses
Comp A – Health Policy and Planning at the MOH (additional indicators)			
MOH completes one year of NHA	No NHA	Draft NHA 2008 presented and discusses	NHA for 2008 and 2009 finalized and presented
MOH completes the Health Sector Masterplan	No Masterplan	Draft Masterplan presented and discussed	Masterplan finalized and presented to Government
MOH completes the Human Resource Rationalization Plan with implementation plan	No HR plan	Draft HR plan presented	HR plan finalized and presented to Government
Comp B – Organizational and Financing Reforms in Health Sector (additional indicators)			
Capitation payment implemented for PHC	10 rayons	20 rayons	41 rayons
Comp C – Strengthening Primary Health Care (additional indicators)			
Family medicine training expanded to 2 more rayons	0 staff trained in 2 additional rayons		184 staff trained in 2 additional rayons
PHC centers equipped with communication system	0 PHC centers		26 PHC centers in 6 rayons
Comp D – Project Coordination and Capacity Building for Implementation (additional indicators)			
MOH completes implementation of Phase 1 Action Plan (Fiduciary Capacity Building)	Fiduciary Unit created	50% of activities under Phase 1 implemented	Phase 1 fully implemented