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Report No: 34080-TJ

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED GRANT

IN THE AMOUNT OF SDR 6.9 MILLION
(US$10.0 MILLION EQUIVALENT)

TO THE

REPUBLIC OF TAJIKISTAN

FOR A

COMMUNITY AND BASIC HEALTH PROJECT

NOVEMBER 23, 2005

Human Development Sector Unit
Europe and Central Asia Region

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CURRENCY EQUIVALENTS

(Exchange Rate Effective October 31, 2005)

Currency Unit = Somoni
3.19 Soms = US$1
US$0.6889 = SDR 1

FISCAL YEAR

January 1 – December 31

ABBREVIATIONS AND ACRONYMS

ADB	Asian Development Bank
ALOS	Average Length of Stay
BPMCS	Basic Program of Medical Care Services
CAS	Country Assistance Strategy
CFAA	Country Financial Accountability Assessment
CPAR	Country Procurement Assessment Review
CQ	Selection Based on Consultants' Qualifications
CRH	Central Rayon Hospital
ECA	Europe and Central Asia Region
FMR	Financial Monitoring Report
GDP	Gross Domestic Product
GNI	Gross National Income
HMIS	Health Management Information System
HPAU	Health Policy Analysis Unit
IBRD	International Bank for Reconstruction and Development
ICB	International Competitive Bidding
ICR	Implementation Completion Report
IDA	International Development Association
IMR	Infant Mortality Rate
IT	Information Technology
LCS	Least Cost Selection
MCH	Maternal and Child Health
MDG	Millennium Development Goals
M&E	Monitoring and Evaluation
MMR	Maternal Mortality Ratio
MIS	Management Information System
MOF	Ministry of Finance
MOH	Ministry of Health
MTBF	Medium Term Budget Framework
MTEF	Medium Term Expenditure Framework
NCB	National Competitive Bidding
NGO	Non-governmental Organization
PBC	Policy-Based Credit
PETS	Public Expenditure Tracking Survey
PHC	Primary Health Care
PHRD	Policy & Human Resources Development Fund
PIU	Project Implementation Unit
POM	Project Operations Manual
PPF	Project Preparation Facility
PR	Public Relations
PRGF	Poverty Reduction and Growth Facility
PRSP	Poverty Reduction Strategy Paper
QCBS	Quality and Cost Based Selection
SA	Special Account
SBD	Standard Bidding Document
SDC	Swiss Agency for Development and Cooperation
SDR	Special Drawing Rights
Sida	Swedish Agency for International Development
	Sanitary Epidemiological Services
SIL	Specific Investment Loan
SOE	Statement of Expenditure
SSS	Single Source Selection
SUB	Rural Hospitals
SWAp	Sector-Wide Approach
TA	Technical Assistance
TB	Tuberculosis
TFR	Total Fertility Rate
TOR	Terms of Reference
U5MR	Under 5 Mortality Rate
UNDP	United Nations Development Program
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

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TAJIKISTAN
COMMUNITY AND BASIC HEALTH PROJECT

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TAJIKISTAN
COMMUNITY & BASIC HEALTH PROJECT

Date: November 23, 2005 Country Director: Dennis N. de Tray Sector Manager: Armin H. Fidler Project ID: P078978 Lending Instrument: Specific Investment Loan	Team Leader: Peyvand Khaleghian Sectors: Health (80%); Compulsory health finance (20%) Themes: Health system performance (P); Other communicable diseases (S). Environmental screening category: Not Required Safeguard screening category: No impact

Project Financing Data

[ ] Loan [ ] Credit [X] Grant [ ] Guarantee [ ] Other:
For Loans/Credits/Others:
Total Bank financing: SDR 6.9 million (US$10 million equivalent)
Proposed terms: N/A – IDA Grant

Financing Plan (US$m)

Source	Local	Foreign	Total
RECIPIENT	0.0	0.0	0.0
IDA Grant	6.0	4.0	10.0
Sida	3.6	2.4	6.0
Total	9.6	6.4	16.0

Recipient:
Republic of Tajikistan

Responsible Agency:
Ministry of Health
Ibn Sino 30 Street, Dushanbe
Republic of Tajikistan
Tel: 24-44-13

Estimated disbursements (Bank FY/US$m)

FY	2006	2007	2008	2009	2010				
Annual	2.2	4.1	4.2	3.5	2.0				
Cumulative	2.2	6.3	10.5	14.0	16.0				

Project implementation period: Start: February 6, 2006 End: August 8, 2009
Expected effectiveness date: February 6, 2006
Expected closing date: February 8, 2010

Does the project depart from the CAS in content or other significant respects? ***Ref. PAD A.3***	[ ]Yes [X] No
Does the project require any exceptions from Bank policies? ***Ref. PAD D.7***	[ ]Yes [X] No
Have these been approved by Bank management?	[ ]Yes [ ] No
Is approval for any policy exception sought from the Board?	[ ]Yes [X] No
Does the project include any critical risks rated "substantial" or "high"? ***Ref. PAD C.5***	[X]Yes [ ] No
Does the project meet the Regional criteria for readiness for implementation? ***Ref. PAD D.7***	[X]Yes [ ] No

Project development objective ***Ref. PAD B.2, Technical Annex 3***
The objective of the proposed project is 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.

Project description *[one-sentence summary of each component]* ***Ref. PAD B.3.a, Technical Annex 4***

i) Strengthening Policy, Planning and Donor Coordination in the Ministry of Health (US$1.46 million baseline cost): 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.

ii) Implementing Organizational and Financing Reforms in the Health Sector (US$4.29 million baseline cost): to finance training, local and international technical assistance, workshops/seminars and study tours to help support the implementation of per capita financing for primary health care and implementation of the Basic Benefit Package.

iii) Strengthening Primary Health Care in Selected Rayons (US$8.06 million baseline cost): 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 and efforts to link health workers and communities more effectively.

iv) Project Coordination and Capacity Building for Implementation (US$0.62 million baseline cost): to finance equipment, operating costs and local technical assistance for a Project Implementation Unit (PIU) consisting of a director, finance officer, procurement officer and procurement assistant to be based in MOH for the purposes of carrying out fiduciary oversight of the Project and building fiduciary capacity in MOH itself.

Which safeguard policies are triggered, if any? ***Ref. PAD D.6, Technical Annex 10***

This project is Category C. The project is limited to rehabilitation of small primary health care facilities (usually 1-5 rooms). It is, however, conceivable that a few facilities might need to be replaced within the existing building footprint, either by *de novo* construction or by installation of prefabricated units. These are expected to pose minimal environmental risks; and the Recipient, though not required to, has prepared an Environmental Management Plan for this contingency.

Significant, non-standard conditions, **if any**, for:

Ref. PAD C.7

Board presentation:

- N/A

Covenants :

- By December 22, 2005, to have: revised the Financial Management Procedures Manual; upgraded the existing accounting software to reflect requirements of the new project; provided training to relevant staff on use and maintenance of the system; tested the system by producing a sample FMR based on PHRD grant expenditures; and recruited the PIU's Financial Manager and Disbursement Specialist/Project Accountant.
- Maintaining a Project Implementation Unit until completion of the Project in a legal and organizational form, with staff, resources and under terms of reference, all satisfactory to the Association.

Grant effectiveness:

- The Recipient, through MOH, shall have adopted the Project Operational Manual satisfactory to the Bank.
- Execution and delivery of the Sida Cofinancing Agreement and fulfillment of all conditions precedent to its effectiveness or to the right of the Recipient to make withdrawals thereunder.

A. STRATEGIC CONTEXT AND RATIONALE

1. Country and sector issues

In the years following the dissolution of the Soviet system, Tajikistan suffered one of the severest economic declines among the former Soviet Republics, exacerbated by years of civil war (1993-1997). By 1996, Tajikistan's real Gross Domestic Product (GDP) was estimated to have contracted to just one third of its 1991 level. While the country began to see some economic recovery in 1998, it remains one of the poorest countries in the world, with Gross National Income (GNI) per capita of just $200 in 2003, and its social infrastructure, including the health system, is in a near-state of collapse. As a consequence, the people of Tajikistan now have one of the poorest health outcomes among the Commonwealth of Independent States (CIS), and their epidemiological profile resembles those of the lowest income countries in the world.

With the return to peace and political stability in recent years, however, Tajikistan appears to be on a road to economic recovery. GDP per capita grew at rates of 7.5% and 6.2% respectively in 2002 and 2003, and there are signs that economic growth is having some positive impact on the life of Tajikistan's 6.3 million people: it is estimated that between 1999 and 2003, the proportion of Tajikistan's population living below the poverty line[1] fell from 81 percent to 64 percent. These trends are corroborated by recent national nutrition surveys, which show a reduction in both acute and chronic child malnutrition rates.[2] Community and household surveys conducted in 1999 and 2003 also suggest some improvements in the quality of health care and access to drugs over this period.[3] That said, Tajikistan needs to reform key sectors and make major investments if it is to meet the Millennium Development Goals (MDGs). The country's economy would need to grow at 3-4 percent per year between 2003 and 2015 in order to meet the MDG related to income poverty, assuming that distribution patterns do not change from those in 2003. It may be possible to meet this goal, although the basis for growth needs to become far more robust. Tajikistan cannot count on past levels of growth and poverty reduction to continue into the future, as much of the recent growth can be attributed to one-time factors such as the cessation of conflict, the initial impact of macroeconomic stability and the large increase in migration – rather than to structural economic reforms. Major and immediate economic reform backed up with substantial investment and institutional strengthening will be necessary even for lower levels of growth to continue. In addition, without sectoral reforms, increased investment and substantial capacity building, it appears unlikely that Tajikistan will meet the nutrition, health, education and environment goals since some of the trends are mostly worsening rather than improving.

At present, the government of Tajikistan spends less than US$1 per capita per year on health services and it has poor health indicators across the board, with an infant mortality rate of ~90/1,000 live births, an under 5 mortality rate (U5MR) of ~120/1,000 live births, a maternal mortality ratio of ~100/100,000 live births, total fertility rate of ~4.0, TB incidence of ~70 case per 100,000 population and long-term malnutrition among children at ~30 percent. The majority of health expenditure is private—and informal, since formal user fees were only introduced recently and the private health sector is extremely small—and affordability is a major problem. According to survey data from 2003, around 57 percent of poor households don't seek health care when necessary because they can't afford to, up from 42 percent in 1998, and the access gap between high and low income groups has also widened in recent years. The proportion of individuals having to pay for health services more than tripled between 1999 and 2003, from 26 percent to 80 percent in the poorest income quintile, and the share of health in household

[1] The poverty line is defined here as living below PPP$2 per day, per *Tajikistan Poverty Assessment Update 2004.*

[2] National Nutrition Surveys, 2001 and 2002.

[3] Based on comparisons of the TLSS 1999 and TLSS 2003 data.

expenditure also rose, from around 5 percent in 1999 to over 9 percent in 2003. Taken as a whole, household health expenditure is now four times greater than government health expenditure, the former accounting for 4.1 percent of GDP and the latter for only 0.9 percent—the lowest in the ECA region. Not surprisingly some ¾ of respondents now identify health as their issue of greatest concern, compared to 24 percent who cite money or jobs.

Tajikistan's health system has a number of structural weaknesses, most of which are common to post-Soviet and transition economies. Primary health care (PHC) is under-emphasized, the hospital network is larger than necessary, hospitals receive the lion's share of public financing and their services are too expensive for the poor, health workers are paid poorly and demand informal payments to compensate, and public health functions such as disease surveillance, human resource development and health promotion are carried out poorly, if at all. There are also significant capacity gaps in health policy, planning and management, both at the central level and among oblast, rayon and facility health administrators. The magnitude of these gaps is masked by the high level of donor-financed and NGO activity, much of which continues to emphasize humanitarian assistance over sustainable development but nevertheless fills critical gaps in service delivery, especially in rural areas but also for poor urban populations. Infrastructure is also a problem, with many clinics and hospitals still bearing the scars of both the civil war and years of neglect. These issues notwithstanding, the government appears committed to strengthening health services and, in particular, to increasing the prominence of primary health care. PHC budgets have been increased annually for the past two years and health worker salaries are set to be doubled in 2006; an experimental package of basic benefits was piloted in two rayons in 2004 and may be scaled up nationally in 2005 along with measures to regulate and inform patients about the price of hospital services; and the government has agreed to a number of budgetary and organizational reforms under the Bank's policy based credit (PBC) that will strengthen the management and flow of funds to PHC services. These are all welcome developments. A number of other proposals are more worrisome—including *inter alia* the proposed introduction of a mandatory social health insurance scheme—but these discussions are at an early stage and there is still little agreement among MOH, MOF and the President's Administration on the best way forward.

The health policy environment in Tajikistan is disorganized. There is limited agreement on an overall strategy for the sector and the level of internal dialogue between key players—MOH, MOF and the President's Administration in particular—is also limited, leading to occasional policy inconsistency. This is mirrored in the pattern of donor activity, which until recently was characterized by weak coordination. Conditions have improved on both fronts over the past year. A handful of clear policy directions have begun to emerge, as further described in the component summaries below, and donor coordination has also improved, partly as a result of better consistency on the government side but partly due to alarm at some of the government's proposals. A joint donor mission on health financing visited Tajikistan in December 2004 and was well-received: similar efforts are likely in future. The project would build on both of these developments, both by supporting areas where the government is clear about its policy intentions and by working directly on strategy development and donor coordination in preparation for a possible future sector wide approach (SWAp).

2. Rationale for Bank involvement

Health is a core objective of the Tajikistan Poverty Reduction Strategy Paper (PRSP) and improvement in sector performance and health status are key objectives of the government's reform program and efforts to meet the MDGs: objectives shared by the Bank's Country Assistance Strategy for Tajikistan which aims to help "preserve and enhance the quality of health and education services." The Ministry of Health (MOH) has demonstrated increasing sophistication over the past few years and is rapidly improving its ability to manage the complex transition from humanitarian assistance to sustainable development. It has also become increasingly open about unresolved challenges in the sector, going so far as to accept the

validity of external reports on health status in Tajikistan even when these do not fully concur with its own data collection efforts. This bodes well for a serious relationship on complex policy and financing reforms such as those currently embarked on by MOH and planned for support under the current project. The Bank has become increasingly engaged in the Tajikistan health sector over the past five years. This would be the second Bank-financed health project in Tajikistan. The Primary Health Care Project (P049894) closed, fully disbursed, in March 2005, and was rated satisfactory. A Health Sector Note was prepared in 2004 and is in the process of dissemination. The Bank's relationship with MOH is good, and the Bank is well positioned to continue coalition-building with other donors. Health also features in the planned PBC operation, with a focus on management and payment reforms in primary care.

3. Higher level objectives to which the project contributes

The current project is included in the CAS and fits in a broader context of public administrative reforms designed to improve transparency, accountability and efficiency in the delivery of public services and the management of public funds. By strengthening the policy analysis and Monitoring and Evaluation (M&E) capacity of MOH, the Project would help MOH to move from its traditional role as a provider of health services to a more contemporary role involving sectoral stewardship and oversight. By supporting the introduction of per capita financing in PHC and case-based payment systems in hospitals, the Project would introduce and help to illustrate the benefits of output-based budgeting methods, acting in tandem with similar efforts in the education sector. By helping to operationalize the basic benefits package (Basic Program of Medical Care Services; BPMCS)—including efforts to promote public awareness of rights and responsibilities—the Project would both improve the efficiency of health spending and promote a culture of transparency in public services. By focusing on PHC and on strengthening community-health worker links with a view to addressing bottlenecks to achieving the MDGs, the Project would create opportunities for communities to hold health workers accountable, albeit modestly given resource constraints and the general political context, and would promote grassroots state-community dialogues. And finally, by concentrating its efforts on reform areas to which the government has already committed itself and is taking fledgling steps, the Project would help bolster the government's confidence and capacity as a policymaker and reform implementer and, if successful, boost the public's confidence in government attempts at reform more generally.

B. PROJECT DESCRIPTION

1. Lending instrument

The project would be a Specific Investment Loan (SIL), financed by an IDA Grant of US$10.0 million equivalent, and by co-financing from Sida equivalent to US$6.0 million. Sida will also finance, in parallel and separate from its co-financing contribution, activities in Component C2.

2. Project development objective and key indicators

The objective of the Project is 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. The following key indicators would be used to assess project performance:

- Decrease in percentage of households in project-supported areas who don't seek health care when necessary because they cannot afford it (baseline, 2003 ~57% of poor households).
- Decrease in share of health in household expenditure in project areas (baseline, 2003 > 9%).
- More equitable distribution of the health budget through implementation of per capita financing in PHC and case-based payment for hospitals.

- Improvement in PHC infrastructure, services and patient satisfaction in project areas.

3. Project components

A. Strengthening Policy, Planning and Donor Coordination in the Ministry of Health (US$1.46 million baseline cost)

This component would 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. The component would support four streams of activity.

A1. Policy Formulation and Analysis. This subcomponent would support the establishment of a Health Policy Analysis Unit (HPAU) in MOH. The HPAU would perform the following analytical functions:

- Monitoring and evaluation of health reforms, concentrating initially on implementation of reforms in primary care and implementation of the Basic Benefit Package;
- Provision of evidence-based advice on policy development in response to MOH needs.

A2. Strategic and Operational Planning. This subcomponent would help build MOH's capacity for strategic planning and for ensuring coherence between sub-sectors. It would do so by helping MOH renew and strengthen its sector strategy, primarily by financing workshops and a small number of local consultants. The strategy would be based on subsectoral strategies—some of which, such as the health financing and HMIS strategies, already exist—and would collect these into a coherent overall strategy through a technically-guided process with transparency and full inclusion of key national and international partners. This would not only improve the coherence of sector policies but also provide a basis for improving coherence in donor-financed activities and a step toward implementing a Sector-Wide Approach (SWAp) in the Tajikistan health sector in future.

A3. Donor Coordination. This subcomponent would help MOH improve donor coordination by financing biannual sector review conferences that would also include high-level government coordination bodies such as the National Board on Health under the Prime Minister's Office and the Aid Coordination Unit in the President's Administration. These would bring together MOH and the donor community for a review of strategies, priorities and modes of support and a review of progress in the health sector.

A4. Public Relations and Communication. This subcomponent would strengthen the public relations capacity of MOH by providing a small budget for PR activities and communication programs.

B. Implementing Organizational and Financing Reforms in the Health Sector (US$4.29 million base cost)

This component would finance training, local and international technical assistance, workshops/seminars and study tours to help support the implementation of per capita financing for primary health care and implementation of the Basic Program of Medical Care Services. This would require two streams of activity—one in PHC and one in hospitals—and would be carried out initially in the 41 rayons of Sughd and Khatlon oblasts. It would also require capacity building in the Economic and Financial Planning Unit of MOH. Three subcomponents are envisaged:

B1. Strengthening PHC Management and Financing. With the introduction of per capita financing and the government's intention to strengthen PHC more generally, the management of PHC services at the rayon level will need to be made distinct from that of hospitals. At present, this relationship is mixed;

some PHC services are financed by rayon budgets and reporting to the Director of the Central Rayon Hospitals, while others are financed by local contributions at lower levels. Policy-Based Credit (PBC) will support a number of measures designed to improve the coherence of PHC management and financing and enable the effective implementation of per capita-based budgeting for PHC. The subcomponent would help build capacity among the newly-formed rayon PHC Departments to manage the network of facilities in their charge.

B2. Strengthening Hospital Management and Implementing the Basic Program of Medical Care Services. Progress has been made in defining and approving a national guaranteed package of basic health services. The BPMCS provides a legal framework for developing the co-payment policy that was legalized with the constitutional referendum in 2004. The BPMCS provides free services for vulnerable population groups and for selected health services. The majority of covered services are in PHC; in hospitals, BPMCS implementation has a different character and will involve moves to formalize informal payments by allowing hospitals to charge for services not covered by the state under the BPMCS: so-called "paid services".

- At the hospital level. The subcomponent would provide furniture, computer and basic software for hospital accounts departments and training for their new role as an active collector of fee revenues and case-based payments vs. a passive recipient of input-driven budgetary funds. The subcomponent would also help develop business plans that link revenue sources for the hospital, both budgetary and from paid services, with their expected use. This would help ensure transparency and accountability.

- At the oblast level. The subcomponent would support the introduction of a purchasing function in the oblast health department—as anticipated by the recently-passed Health Finance Strategy—and would provide the unit with management training, computers and a server to receive and process hospitals' payment claims for services and individuals covered under the BPMCS. Software for this function would likely be developed *de novo* but would be made complementary to an existing hospital MIS. Provisions would also be made for periodic and in-service training of oblast staff, probably in conjunction with counterparts in MOH, and for hiring of local IT consultants to maintain servers and provide IT support. The subcomponent would also support the oblast health department to disseminate information to patients on their rights under the BPMCS and create opportunities for redress in cases of abuse, especially regarding co-payments for paid services.

B3. Strengthening MOH Oversight of Organizational and Financial Reforms. This subcomponent would strengthen hospital policy development in the Economic and Financial Planning unit of MOH. Specific tasks would include: 1. Refining output-based budget formulation methods, initially focusing on the refinement of the PHC per capita financing, costing and fine tuning of the BPMCS; 2. Applying output-based budget formulation to the development of the Medium-term Budget Framework and the annual budget process; and 3. Monitoring health financing indicators with the objective of developing a baseline National Health Accounts. The unit would also carry out community surveys and Public Expenditure Tracking Survey (PETS), working closely with the HPAU envisaged under Component A and having survey-related costs financed by the project.

C. Strengthening Primary Health Care in Selected Rayons (US$8.06 million baseline cost)

This component would 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 and efforts to link health workers and communities more effectively.

C1. Strengthening the PHC Infrastructure. This subcomponent would rehabilitate or replace PHC facilities in 2-4 rayons in Sughd and Khatlon oblasts. The selection of rayons will be made on the basis of a PHC rationalization plan being prepared under the PHRD grant and would use complementary information from a recent health facilities survey.

C2. Strengthening PHC services and outreach. {This subcomponent to be financed in parallel by Sida.} A weakness of the current PHC system is the lack of engaged dialogue between PHC providers and the communities they serve. This is problematic in a country where IMR, U5MR and MMR are high, and where many bottlenecks to service delivery could be relieved with greater attention to the PHC-community interface. To promote this dialogue and improve PHC services in project rayons, the subcomponent would finance: first, technically-guided dialogue, prioritization and micro-planning between health workers and communities; and second, a small grants program to back it up. Health workers and communities would be brought together on a regular basis over the course of three years to identify service delivery bottlenecks and prioritize solutions. This would initially be guided by external agents—e.g. a firm or NGO with experience of the health sector, community mobilization and small grants programs—but these agents would be progressively joined by staff from the rayon PHC department in order to build supervision capacity on their part. The objective would be to broker a technically-grounded dialogue on priority health needs and help to address them.

C3. Strengthening PHC training. This subcomponent would, at a minimum, finance re-training of all PHC workers in project rayons under an approved family medicine training scheme. Given the chaotic state of health worker training in Tajikistan, it will be essential to identify an approach to health worker training that is transparent in nature, avoids duplication, is sustainable, responds to the country's priority health needs and capacity for training and is agreed to by multiple donors.

D. Project Coordination and Capacity Building for Implementation (US$0.62 million baseline cost)

This component would finance equipment, operating costs and local technical assistance for a Project Implementation Unit (PIU) consisting of a Director, Deputy Director, Financial Management Specialist, Procurement Specialist, Procurement Assistant, Chief Accountant, Cashier, Legal Advisor, Office Manager and Assistant, Translator, drivers and other auxiliary staff. Project coordination and management of civil works would also be managed by the PIU, as would as field supervisors as needed to oversee civil works. As opposed to the previous PHC project, component specialists would be co-located with counterparts in MOH so that technical and policy functions would be carried out *within* MOH with the support of local consultants as necessary. The PIU would also be responsible for monitoring and evaluation of the project, maintaining and updating project indicators and integrating these into quarterly reports, as required.

4. Lessons learned and reflected in the project design

The Tajikistan Primary Health Care Project closed at the end of March (2005). A central component of the project was the development of a health rationalization plan and the construction of 25 rural health centers. Key lessons from this process included the recognition of the political and technical complexity of rationalizing health facilities, especially hospitals, in a post conflict country with high poverty, very weak infrastructure and geographical challenges. It is difficult to overemphasize the complexity of supervising a large number of far-flung civil works to be completed on time and at a reasonable cost. The new project will emphasize closer work with local communities to build ownership and support, not only among the rural health facilities and in rural finance but also among local stakeholders. Very close planning and supervision of the process is critical, as well as close collaboration with stakeholders at the national and local levels.

There is a compelling need for policy-based lending to complement project activities and support institutional reforms such as those in health financing. It is also essential to "anchor" activities in the country's policy or program context to ensure sustainability. On a more positive note, the recent Project benefited from increasing maturity in the Tajikistan health sector and substantial improvements in the openness and technical content of health policy dialogue, especially in the latter years of Project implementation. The proposed Project will build on and expand on this dialogue.

Twice during the course of the Primary Health Care Project complementary and critical activities to be funded by Bank partners, and with direct impact on the Bank project, failed to be implemented. It is essential for activities that will have an impact on project outcomes, that any understandings or agreements reached with other partners be planned and agreed to in such a way as to preclude this from happening again.

5. Alternatives considered and reasons for rejection

As stated above, the Primary Health Care Project was largely successful so there was a fairly strong consensus that there should be a follow-on project of some kind. Options considered but rejected included the following:

- Policy Based Operation. This option was rejected because Tajikistan's investment needs are substantial given the impact of economic collapse and civil war on capital stock in general and on the country's health infrastructure in particular. Relatively few donors are able to finance civil works in Tajikistan and their resources are limited; this underscores the need not only for investment but also for appropriate and objective targeting of these investments and the development of sustainable, cost-effective models. The cost of rehabilitating the PHC infrastructure alone is estimated at around US $120 million; therefore, what matters most is to develop an agreed-on, cost-effective approach to infrastructure redevelopment in Tajikistan that can be a basis for attracting additional donor support in future, given the inability of the Tajikistan budget to meet these needs now or indeed for the foreseeable future.

- Sector-Wide Approach (SWAp). There are several reasons against moving to a SWAp arrangement immediately: (i) although it is improving, donor coordination in the health sector has been somewhat weak; (ii) the MOH does not have a widely-agreed health sector strategy that is actively used as a basis for policy and strategy in the sector; and (iii) overall, the capacity of the MOH remains quite low. Nevertheless, elements in the design of the proposed project, such as capacity building, donor coordination and financing, will help to lay the groundwork for a health SWAp which could be initiated as early as 2008 (according to the new CAS July 26, 2005).

- Focusing on service delivery rather than structural reform. Given the dire state of Tajikistan's health sector and its health indicators, it could be argued that a more immediate impact on MDGs could be obtained with a highly targeted project focused exclusively on improving communicable disease control or maternal mortality at the grassroots level. This approach was rejected for several reasons. First, the donor field in Tajikistan is crowded with NGOs and UN agencies active at the grass-roots, many of whom have made a significant difference to health status through targeted interventions but whose programs, collectively, have failed to translate into improved performance of the *public* health sector. Second, part of this phenomenon—i.e. the failure of grass-roots demonstration effects to stimulate improved performance in the public health delivery system—is explained by incentive problems and structural failings in the public delivery system itself, such as the inequitable distribution of PHC funds, problems with the flow of funds in the health sector and the lack of an appropriate incentive system (e.g. case-based payments vs. input-based budgets) for efficient and effective performance by health institutions and their staff. These are being addressed by the

proposed Project. Third, the Bank's comparative advantage is in health sector reform, and it is here that the Bank's assistance has been specifically sought based on extensive dialogue during preparation of the *Tajikistan Health Sector Note* and in follow-up discussions. Fourth, Tajikistan's MDG problems do not stop at health indicators but also include significant and worsening inequalities in the burden of health financing and out-of-pocket payments. The reforms being supported here are intended to address this issue in a way that disease-focused interventions would not.[4] Fifth, and most important, the GOT recently embarked on an ambitious structural reform program in the health sector that will require a combination of technical expertise and investments in cost-effective IT systems, policy analysis and monitoring and evaluation to make it work properly. Again, among donors active in the health sector, only the World Bank and ADB are equipped to provide such a combination of policy-based and investment support, and it was, therefore, agreed to pursue a three-pronged approach—combining capacity-building, support for health reform implementation *as well as investments in PHC infrastructure and service delivery* (Component C)—rather than a more narrowly focused approach.

- Stronger emphasis on planned rationalization of health facilities. A major drain on Tajikistan's health resources is its oversized and underutilized hospital sector, with average occupancy rates at between 30-50%. The introduction of case-based payments is designed to address these issues by creating incentives for hospitals to match costs to the actual volume of services delivered. The other alternative—planned rationalization *without* changes in the incentives regime—is politically complex and seldom succeeds because of the influence of vested interests and their resistance to government-led decisions to rationalize the hospital sector. Experience with PHC rationalization in the previous Primary Health Care Project illustrates this phenomenon, as do similar efforts elsewhere in ECA. For this reason, the approach being taken now—led by the government and its decision to establish a Basic Benefit Package—is to stimulate rationalization in the first place through payment system reform, and to follow this with planned rationalization in 4-5 years, once initial efficiency gains have been obtained and several years' data on hospital utilization has been accumulated by the new hospital information and payment system.

C. IMPLEMENTATION

1. Partnership arrangements

A key partnership in the current project will be Sida. Sida has agreed to provide $6 million in cofinancing for the project and to delegate project management and supervision to the Bank. Sida's offer of cofinancing came late in project development but there is considerable agreement between Sida's health team and the Bank on the design of the project and the strategic priorities to be addressed. Sida will also support the sector through parallel financing of Component C2 via direct grants to 2-3 NGOs to help strengthen PHC service delivery in Tajikistan. Sida specialists will also be invited to join supervision missions, though the responsibility for project supervision will rest with the Bank. The Bank and Sida are also in discussions with WHO/EURO in Copenhagen and the DfID-WHO Health Policy Analysis Project in the Kyrgyz Republic about a possible twinning arrangement between the Kyrgyz and Tajik Health Policy Analysis Units, and a medium-term technical supervision and support arrangement from WHO/EURO.

Partnerships have been a critical part of the health sector in Tajikistan and their range and scope have increased substantially in recent years. A large number of donors are active in the health sector. Some,

[4] Note that according to the World Health Organization's *World Health Report 2000*, financial protection against the cost of illness is given equal rank with health outcome indicators such as IMR, U5MR, MMR etc.

such as USAID-funded ZdravPlus, SDC-funded Project Sino and WHO, have played an active role in conceptualizing and designing the present project. A broader group, including UNICEF and ADB, have been active participants in policy dialogue around implementation of the Basic Benefit Package and per capita financing in the health sector. The Aga Khan Foundation played an active role in the first Bank-financed project and in background studies for the Bank's Tajikistan Health Sector Note that was issued in 2005; other NGOs have taken an active interest in the Bank's support to primary care. Many of these partnerships are expected to continue during the implementation of the project. In particular, policy dialogue on financing and organizational reform issues has become increasingly a multi-donor affair, with extensive informal collaboration and even joint missions. These will continue but are likely to become progressively more formal as the MOH's capacity to coordinate donors improves with the implementation of "Health Summits" and other activities proposed in Components A2 and A3.

2. Institutional and implementation arrangements

Implementation of the new project will be done through the Project Implementation Unit on behalf of the MOH. However, to promote better integration of the PIU with MOH and other partners, and to help build the MOH's internal capacity in project implementation and related functions, two changes are proposed: first, over the course of the Project, a shift in premises so as to move the PIU into MOH; and second, a shift in staffing whereby component specialists would be based alongside their direct counterparts in the MOH rather than in the PIU. It is recognized that space limitations may prevent the entire PIU from moving into MOH premises immediately, especially since the PIU will need to retain and possibly expand its staffing on the civil works front; but for component specialists, the advantages to MOH in terms of capacity building and knowledge transfer are significant enough to warrant strenuous efforts to accommodate them on-site, the same being true in due course for the core PIU vis-à-vis capacity building in fiduciary functions and project implementation.

The PIU will carry out the day-to-day activities of the Project which will include: procurement; project accounting and financial reporting; monitoring and evaluation; administering of special accounts and withdrawal applications for disbursements; and coordination of external audit arrangements. The PIU has installed an accounting software that will only need to be adapted to be able to generate reports required under the proposed project.

The PIU has successfully implemented the now-closed Primary Health Care Project, and is currently implementing the PPF and PHRD financed preparation of the proposed project. Staff have gained significant experience with financial management, procurement and disbursement procedures of the World Bank. The PIU has established a financial management system that is capable of monitoring resources and expenditures of the project and generating reports, such as Financial Monitoring Reports. The PIU financial manager from the first Project has been replaced by a suitably qualified and experienced financial manager, and who will participate in the establishment of a financial management system capable of recording all transactions and balances, and support the preparation of Financial Monitoring Reports (FMR). This is a condition of project effectiveness. This financial manual will also will be part of the Project Operations Manual (POM), the adoption of which is also a condition of effectiveness. The manual of financial procedures prepared for the previous project will need to be revised to reflect the financial management requirements of the new project.

3. Monitoring and evaluation of outcomes/results

MOH, through the PIU, will monitor and evaluate implementation progress and outcomes of the project. As part of Component A1 (Policy Formulation and Analysis), a Health Policy Analysis Unit (HPAU) will be established in the MOH. The HPAU would be based under the MOH's Department for Planning, Coordination and Implementation of Health Reforms. The Unit would be responsible for monitoring and evaluating health reforms, concentrating initially on implementation of reforms in primary care and implementation of the Basic Benefit Package, but taking on greater responsibility through the life of the project. It will be critical for the PIU to establish a close working relationship with HPAU and share information and results. Annex 3 summarizes which indicators would be collected by the PIU and which ones by the HPAU. A PHRD-funded household survey with over-sampling in project oblasts was carried out in March 2005 to provide a baseline for the new project and to facilitate post-project evaluation of the Primary Health Care Project. A similar survey will be carried out in Year 4 to facilitate post-project evaluation of the current project as well. Analysis will be carried out by the HPAU.

4. Sustainability

The project aims to achieve sustainability in several ways.

- By focusing on MOH, i.e. in Component A, the project aims to develop capacity for sector planning, policy-making and stewardship that will last beyond the project and have externalities beyond the specific areas being supported therein. This is especially true of efforts to lay the foundations for a SWAp, including strengthening Tajikistan's existing health sector strategy, converting this into a medium-term work program and budget and institutionalizing periodic sector review meetings and improvements in donor coordination.

- By concentrating on structural reforms, i.e., in Component B, and by implementing these over a large and representative share of the country, the project aims to improve the efficiency and effectiveness of the health system in a way that goes beyond piloting reforms and lends itself to rapid adoption nationally. The team and other donors have advised GOT to take a phased approach rather than rushing headlong into complicated reforms that will take time to mature; it is hoped that this approach will also be conducive to sustainability, both by improving the likelihood of success and allowing time for lessons to be learned and stakeholders to be fully brought-in.

- By focusing on primary care, i.e. in Component C, the project would refine a cost-effective package of investments and service delivery improvements in PHC that can be replicated across the country, building on work started under the Primary Health Care Project. As such, it has been agreed with MOH that many project activities—such as the development of revised building norms and standard design packages for PHC—should be seen as efforts to develop nationally-applicable standards and norms for the entire sector rather than for the project alone.

The issue of fiscal sustainability is addressed in Section 5, Section D.1 and Annex 9.

5. Critical risks and possible controversial aspects

Risk	Risk Mitigation Measure	Risk Rating with Mitigation
To Project Development Objective		
Overall:		
Slower-than-expected economic growth reduces government revenue and/or allocations to health sector, impeding GOT's ability to maintain project-funded civil works, equipment, etc.	PHC spending has increased progressively for past 8 years; a further 40% is planned for CY 2006 and should be sufficient to cover all new recurrent costs generated by project investments.	M
Civil service reforms proceed more slowly than expected, creating a 'drag' on institutional reforms in the health sector.	Health features in all proposed development policy operations including the PBC and PRSC series, under the civil service reform heading; selected reforms introduced in health as a demonstration ministry for institutional change, e.g. strategy development, fiduciary capacity development and pay reform; and others not dependent on the broader civil service environment, e.g. policy analysis.	M
Component A:		
Volatile policymaking undermines the agreed reform program.	Bank engages in continuous health policy dialogue with MOH rather than in periodic, project-based supervision alone; HPAU provides evidence-based advice to MOH (A1); move toward inclusive, multi-donor sector monitoring efforts (A3); support from Development Policy Lending.	H
Anti-reform elements in health sector gain prominence through changes in key personnel/ political situation, cause return to input-based financing and non-evidence-based policy making.	Efforts ongoing to build horizontal and vertical consensus and ownership of reform process in MOH (A2); interdepartmental and sectoral conferences financed by project (A3); HPAU engages in continuous provision of evidence-based advice (A1).	S
Populist pressure results in complete abandonment of co-payments, increasing health sector's funding constraints.	HPAU research, sector summits, PR campaign increase understanding that co-payments replace otherwise unavoidable informal payments (A1, A3, A4).	S
Structural and financing reforms fail due to inertia or internal conflict within MOH and undermine the basis of health reform, e.g. failure to distinguish PHC and hospital management and financing, failure to properly implement BPMCS.	Policy foundations of reforms supported by PBC, laid out in Letter of Development Policy, further supported by future PRSCs.	S

Risk	Risk Mitigation Measure	Risk Rating with Mitigation
Lack of understanding of reforms at MOF and PA leads to policy and staffing decisions that hamper or set back the reform process.	HPAU research, sector summits, PR campaign increase understanding of reform specifics and their fiscal/human resource impact (A1, A3, A4).	S
Donors neglect priorities of emerging sector strategy.	Sector review conferences bring together all donors in attempt to build consensus, consider priorities of all donors (A3).	M
Component B:		
BPMCS fails to reduce informal payments, either because of failure of implementation of payment reforms, failure of HMIS, inadequate patient-provider communication, and/or inadequate accountability measures.	Management training for BPMCS implementation provided at rayon, oblast, and national levels (B2); PR strategy implemented at national and oblast levels (A4); opportunities for redress created at oblast level (B2).	H
Component C:		
Renewal of PHC facilities does not lead to increased usage because of failure of reform efforts to reduce informal payments.	Policy foundations of reforms supported by PBC and Letter of Development Policy; management support provided at all levels (B1-3); PR supported at national and oblast levels (A4); opportunities for redress created at oblast level (B2).	S
Geographic barriers prevent increased utilization of renewed PHC facilities.	Small grants program allows communities to address some barriers to service delivery (C2).	M
Trained PHC workers, healthcare administration staff migrate out of sector or country because of low pay.	Increased PHC funding, salaries (note: not addressed directly by the project); improvement in working conditions (C1, C2), training opportunities (C3), and management (B1, B2).	S
Small grants managed poorly by communities.	**(NOTE: C2 parallel-financed by Sida).** Community dialogue establishes/ strengthens institutional community structures for health issues prior to grant process; inclusive bid process for consultancy identifies NGO capable of thorough oversight of and assistance to grant recipients (C2).	
To Component Results **Overall:**		
Lack of oversight and accountability by MOH hinders project implementation.	Most project-funded staff located within MOH to facilitate close collaboration and capacity building; PIU performs continuous M&E (A1-4, B1, B2, D).	M

Risk	Risk Mitigation Measure	Risk Rating with Mitigation
Component A:		
Conflict between MOH staff and project-funded consultants prevents integration of HPAU, other consultants into efficient functioning of MOH.	Project-funded staff work not only on new initiatives but also provide support to existing staff in their work; interdepartmental meetings and sector conferences increase understanding of need for cooperation, collaboration; project funds Internet access for all staff.	S
Working groups fail to meet regularly, or meet but do not progress towards development of sub-sector strategies.	Regular interdepartmental meetings increase appreciation of need for coordination, completion of strategies; PIU monitors progress, directs TA to priority groups (A2).	M
Component B:		
Output of HMIS and/or PHC and hospital management consultancies are ill-suited to sector needs.	Inclusive bid processes take into account the needs of all stakeholders; size of consultancy contracts attract most experienced, capable bidders (B1, B2).	M
Component C:		
Political capture of site selection process for civil works directs project resources away from priority rayons.	Objective criteria for site selection developed by an independent health planner under the PHRD grant. (C1)	M
Corruption and/or a lack of capable contractors reduce quality of civil works.	Size of consultancy contract attracts most experienced, capable bidders; PIU provides thorough oversight (C1; D).	S
Poor NGO-health worker-local government-community communication prevents identification of community priorities for improving service delivery.	**(NOTE: C2 parallel-financed by Sida).** NGO contract awarded with consideration for required sensitivities (C2); size of consultancy contract attracts most capable NGOs with experience in grass-roots work (C2).	
Conflict between NGO contracted for C2 and other NGOs in the region.	**(NOTE: C2 parallel-financed by Sida).** Inclusive bid process takes into account the needs of all stakeholders (C2); sector review conferences aim to involve all stakeholders in building consensus, increasing collaboration (A3).	
Infighting resumes between training institutions over the choice of curriculum for primary health care training.	Sector review conferences increase appreciation of need for agreed-upon strategy, create pressure on institutions to resolve conflict (A3).	S
PHC Staff unwilling to participate in training.	Modest financial incentives for training provided (C3).	N
Curriculum, trainers for PHC training weak.	Content of nationally-agreed upon curriculum reviewed by PIU; quality of training observed by PIU (C3).	N

Risk	Risk Mitigation Measure	Risk Rating with Mitigation
Component D: Lack of sufficient oversight by PIU.	Close collaboration between PIU and MOH increases MOH's understanding, participation and tracking of project process and outcomes (A2, A3, D); WB and Sida track PIU's work through biannual PIU reports, regular visits and close communication.	M
Overall Risk Rating		S

6. Loan/credit conditions and covenants

By Effectiveness:

- Adoption of Project Operations Manual acceptable to IDA.
- Execution and delivery of the Sida Cofinancing Agreement and fulfillment of all conditions precedent to its effectiveness or to the right of the Recipient to make withdrawals thereunder.

Covenants:

- By December 22, 2005, to have: revised the Financial Management Procedures Manual; upgraded the existing accounting software to reflect requirements of the new project; provided training to relevant staff on use and maintenance of the system; tested the system by producing a sample FMR based on PHRD grant expenditures; and recruited the PIU's Financial Manager and Disbursement Specialist/Project Accountant.
- Maintaining a Project Implementation Unit until completion of the Project in a legal and organizational form, with staff, resources and under terms of reference, all satisfactory to the Association.

D. APPRAISAL SUMMARY

1. Economic and financial analyses

The fiscal impact of the Project was conservatively estimated at ~USD $1.1 million per annum. The majority of expenditures will be incurred under the PHC budget, given the Project's focus on investment and capacity building in PHC. GOT, with support from the proposed Policy Based Credit, has committed to increase the 2006 PHC budget in 2006 by 40% over the 2005 level following similar increases in the past two years. With a total PHC budget of USD $5 million in CY2005, this translates to an increase of USD $2 million. Assuming the increase is split 40:60 between salaries and non-salary recurrent expenditures in PHC, the latter would increase by USD $1.4 million: i.e. fractionally more than the amount required to cover additional expenditures engendered by the Project. Because these additional expenditures were estimated conservatively, e.g. assuming immediate need for full maintenance on new facilities and including a higher-than-expected allowance for inflation, the Project's investments are considered fiscally sustainable within a reasonable margin of error.

2. Technical

The technical basis of the proposed operation is sound; by focusing on strengthening primary health care and helping introduce elements of a basic package of health benefits, the Project can be expected to improve equity, efficiency and fiscal sustainability in Tajikistan's health sector. Also, while institutional reform in fragile states is never straightforward, the Project's focus on MOH capacity building is essential

to ensuring that reforms are carried out efficiently and effectively and are sustained beyond Project completion, especially financing reforms that will take considerably longer than five years to mature and will continue to require refinement and calibration even if successfully implemented from the outset. The benefits of supporting development of a sector strategy are also self-evident, especially in the context of proposed moves toward a SWAp in 2009.

3. Fiduciary

An assessment of the financial management arrangements of the PIU, under the MOH, was carried out in June 2005 to determine if the management arrangements are satisfactory to the Bank. Financial management arrangements include systems of budgeting, accounting, financial reporting, auditing, and internal controls. The existing PIU has been implementing the Primary Health Care Project, and staff have gained experience with World Bank procedures for financial management and disbursement. The PIU uses the 1-C accounting software to track resources and expenditures and prepare reports required for monitoring project performance and progress. The PIU has been audited annually and satisfactory audit reports have been submitted to the Bank on time. This assessment supplemented the financial management supervision conducted in January 2004 that determined that the financial management arrangements of the PIU, including internal control procedures, are satisfactory to the Bank. However, due to the recent departure of the PIU financial manager, a suitable replacement will be required, before Board Presentation, as part of further capacity enhancements needed in the financial management arrangements in order to be fully satisfactory to the World Bank.

4. Social

No adverse social consequences are anticipated from the Project. All rehabilitation or construction of civil works will be done on existing sites and there will be no exclusion of people from access to land or resources. The Project's focus on reducing access barriers for primary health care and essential hospital services is expected to have substantial social benefits. This will be especially the case for children, women of child-bearing age and other vulnerable groups, both because of its focus on PHC—where a large share of key services are delivered—and because these groups slated for exemption from fees under the basic benefit package currently being piloted in Varzob and Dangara rayons and now proposed to be scaled up in Sughd and Khatlon oblasts. The Project's expected impact can be illustrated with reference to the following summary of issues facing the health sector in Tajikistan:

1. Almost one in ten children die in infancy: IMR in 2001 was 87 per 1,000 live births: a figure that compares with IMRs in Rwanda and Congo. There has been little change since 1992, when IMR was 82. Under-5 Mortality Rates are also high, at around 110 deaths per 1,000 live births.
2. Maternal mortality is high: the Maternal Mortality Ratio in Tajikistan is reported at 50 per 100,000 live births but is probably higher—around 100—due to under-reporting.
3. The nutritional status of children has improved somewhat: between 2001 and 2003, the prevalence of long-term malnutrition declined very slightly—reflecting ongoing problems with food security—but that of acute malnutrition fell from 17 to 5 percent.
4. Infectious diseases are getting worse: between 1995 and 2002, the incidence of diarrheal diseases increased by 25 percent and the incidence of typhoid doubled, from 26.6 to 52.2 cases per 100,000. TB is also a major threat—and worsening. TB incidence quadrupled between 1993 and 2002, from 12 cases per 100,000 in 1993 to 64 per 100,000 in 2002.
5. Along with health status, the affordability of health services is also declining: in 2003, around 57 percent of poor households did not seek health care when necessary because they couldn't afford to, up from 42 percent in 1998. Affordability is the biggest barrier to access.
6. More and more people are paying out of pocket for health services: the proportion of individuals having to pay for health services more than tripled between 1999 and 2003, from 26 percent to 80

percent in the poorest income quintile, and the proportion of household income spent on health is increasing rapidly.

7. The access gap between rich and poor is widening; meanwhile, government health spending has been declining. Government health expenditure fell from 1.1% of GDP in 1999 to 0.9% in 2003—well under half the average for low-income countries and easily the lowest in the ECA region.

From this list, the proposed Project would address items 1, 2 and (to some extent) 4 by investing in infrastructure, training and strengthening of service delivery in PHC, in Component C; and items 5, 6 and 7 through the capacity-building, policy analysis and structural reform measures summarized in Components A and B. Given the wide range of non-health-system factors that impact health—e.g. poverty for nutritional status and water supply for water-borne diseases—and the time lag between interventions and health outcome improvements, the magnitude/speed of the Project's impact on items on 1, 2 and 4 is difficult to judge.

5. Environment

This project is Category C. The project is limited to rehabilitation of small primary health care facilities (usually 1-5 rooms). It is, however, conceivable that a few facilities might need to be replaced within the existing building footprint, either by *de novo* construction or by installation of prefabricated units. These are expected to pose minimal environmental risks; and the Recipient, though not required to, has prepared an Environmental Management Plan for this contingency.

6. Safeguard policies

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment (OP/BP/GP 4.01)	[ ]	[X]
Natural Habitats (OP/BP 4.04)	[ ]	[X]
Pest Management (OP 4.09)	[ ]	[X]
Cultural Property (OPN 11.03, being revised as OP 4.11)	[ ]	[X]
Involuntary Resettlement (OP/BP 4.12)	[ ]	[X]
Indigenous Peoples (OD 4.20, being revised as OP 4.10)	[ ]	[X]
Forests (OP/BP 4.36)	[ ]	[X]
Safety of Dams (OP/BP 4.37)	[ ]	[X]
Projects in Disputed Areas (OP/BP/GP 7.60)*	[ ]	[X]
Projects on International Waterways (OP/BP/GP 7.50)	[ ]	[X]

* By supporting the proposed project, the Bank does not intend to prejudice the final determination of the parties' claims on the disputed areas.

7. Policy Exceptions and Readiness

There are no policy exceptions in the proposed Grant.

Annex 1: Country and Sector or Program Background

TAJIKISTAN: COMMUNITY AND BASIC HEALTH PROJECT

Sector Background

At present, the government of Tajikistan spends less than US$1 per capita per year on health services and it has poor health indicators across the board, with an infant mortality rate of ~90/1,000 live births, a child mortality rate of ~120/1,000 live births, a maternal mortality ratio of ~100/100,000 live births, total fertility rate of ~4.0, TB incidence of ~70 case per 100,000 population and long-term malnutrition among children at ~30 percent. The majority of health expenditure is private—and informal, since formal user fees were only introduced recently and the private health sector is extremely small—and affordability is a major problem. According to survey data from 2003, around 57 percent of poor households don't seek health care when necessary because they can't afford to, up from 42 percent in 1998, and the access gap between high and low income groups has also widened in recent years. The proportion of individuals having to pay for health services more than tripled between 1999 and 2003, from 26 percent to 80 percent in the poorest income quintile, and the share of health in household expenditure also rose, from around 5 percent in 1999 to over 9 percent in 2003. Taken as a whole, household health expenditure is now four times greater than government health expenditure, the former accounting for 4.1 percent of GDP and the latter for only 0.9 percent—the lowest in the ECA region. Not surprisingly some ¾ of respondents now identify health as their issue of greatest concern, compared to 24 percent who cite money or jobs.

Tajikistan's health system has a number of structural weaknesses, most of which are common to post-Soviet and transition economies. Primary health care is under-emphasized, the hospital network is larger than necessary, hospitals receive the lion's share of public financing and their services are too expensive for the poor, health workers are paid poorly and demand informal payments to compensate, and public health functions such as disease surveillance, human resource development and health promotion are carried out poorly, if at all. There are also significant capacity gaps in health policy, planning and management, both at the central level and among oblast, rayon and facility health administrators. The magnitude of these gaps is masked by the high level of donor-financed and NGO activity, much of which continues to emphasize humanitarian assistance over sustainable development but nevertheless fills critical gaps in service delivery, especially in rural areas but also for poor urban populations. Infrastructure is also a problem, with many clinics and hospitals still bearing the scars of both the civil war and years of neglect. These issues notwithstanding, the government appears committed to strengthening health services and, in particular, to increasing the prominence of primary health care. PHC budgets have been increased annually for the past two years and health worker salaries are set to be doubled in 2006; an experimental package of basic benefits was piloted in two rayons in 2004 and may be scaled up nationally in 2005 along with measures to regulate and inform patients about the price of hospital services; and the government has agreed to a number of budgetary and organizational reforms under the Bank's PBC that will strengthen the management and flow of funds to PHC services. These are all welcome developments. A number of other proposals are more worrisome—including *inter alia* the proposed introduction of a mandatory social health insurance scheme—but these discussions are at an early stage and there is still little agreement among MOH, MOF and the President's Administration on the best way forward.

The health policy environment in Tajikistan is disorganized. There is limited agreement on an overall strategy for the sector and the level of internal dialogue between key players—MOH, MOF and the President's Administration in particular—is also limited, leading to occasional policy inconsistency. This is mirrored in the pattern of donor activity, which until recently was characterized by weak coordination. Things have improved on both fronts over the past year. A handful of clear policy directions have begun to emerge, as further described in the component summaries below, and donor coordination has also

improved, partly as a result of better consistency on the government side but partly due to alarm at some of the government's proposals. A joint donor mission on health financing visited Tajikistan in December 2004 and was well-received: similar efforts are likely in future. The project would build on both of these developments, both by supporting areas where the government is clear about its policy intentions and by working directly on strategy development and donor coordination in preparation for a future SWAp.

Tajikistan needs to reform key sectors and make major investments if it is to meet its Millennium Development Goals. The country's economy would need to grow at 3-4 percent per year between 2003 and 2015 if it is to meet the MDG relating to income poverty, assuming distribution patterns do not change from those in 2003. It may be possible to meet that goal, although the basis for growth needs to become far more robust. Tajikistan cannot expect past levels of growth and poverty reduction automatically to continue into the future, as much of the growth can be attributed to one-time factors such as the cessation of conflict, the initial impact of macroeconomic stability, and the large increase in migration, rather than to structural economic reforms. Major and immediate economic reform backed up with substantial investment and institutional strengthening will be necessary even for lower levels of growth to continue. In addition, without sectoral reforms, increased investment and substantial capacity building, it appears unlikely that Tajikistan will meet the nutrition, health, education and environment goals, because some of the trends are mostly worsening rather than improving. The Tajikistan Poverty Reduction Strategy Paper (2002) identifies health as one of the priority sectors for the Government's medium-term investments and reform agenda, and adopts the international Millennium Development Goals for its medium-term strategy.

Health Financing

In Tajikistan, private out-of-pocket payments are the most important source of financing for the health sector (Table 1). In 2003, Tajikistan spent about US$11.60 per capita (current $US) on health care (Table 2). This translates into 5.8 percent of GDP, which is quite high as compared with the CIS-7 countries. However, public spending on health is less than 1 percent of GDP, which is the *lowest* among the CIS-7. [5] This indicates that out-of-pocket spending for health is the primary source of financing. Sources of funds analysis shows that out-of-pocket payments constitute 71 percent of total health expenditures, donors contribute 13 percent and the remaining is public financing (16 percent). Households contribute 96 percent of funds for outpatient drugs, 61 percent of funds for outpatient services, 52 percent of the funds for inpatient drugs and 37 percent of funds for hospital services.

Excessive dependence on out-of-pocket payments generates access barriers for the poor and vulnerable. Household surveys show that utilization of health services among the poor is almost half that of the non-poor. The poor are also less likely to be hospitalized than the wealthy (1.9 percent versus 5.1 percent respectively). Between 1999 and 2003, out of pocket spending for health care has increased and the hospitalization rate for all income groups declined from 5.2 percent to 3.3 percent of the total sample. The poor are more likely to use ambulatory care, either a home visit by a provider or a visit to a rural primary health care facility or urban polyclinics. Individuals from the highest expenditure quintile are likely to visit an inpatient facility and many times more likely to visit a tertiary hospital in the capital.

Public financing for health is extremely fragmented across Republican (national), oblast (regional), rayon (district) and jamoat (village) administrative levels. There are concerns with the allocative and technical efficiency and geographic equity of public spending on health. Budget formulation is based on the old Soviet system of allocation according to inputs (e.g. the number of hospital beds). This naturally leads to hospitals consuming the bulk of public financing while primary health care is starved for funds. In 2003,

[5] The CIS7 countries include: Albania, Azerbaijan, Georgia, Kyrgyz Republic, Moldova, Tajikistan and Uzbekistan.

secondary and tertiary care consumed more than 75 percent of public funds. There is also lack of transparency and accountability in the flow of funds for primary care, since PHC funds normally flow through hospitals, polyclinic or jamoats (local village councils) and there is plenty of scope for diversion, especially of any non-salary allocations. The service delivery network is large and duplicative and there is scope for rightsizing the network. Informal payments are rampant.

Table 1: Distribution of Health Care Expenditures, by Sources and Service Categories, 2003

		By Sources		
Service category	**% of total health spending**	**Government Budget**	**Household**	**Donors**
1. Hospitals	33%	32%	42%	26%
Services	22%	41%	37%	22%
Drugs	11%	13%	52%	35%
2. Ambulatory Care	64%	3%	90%	7%
Services	12%	14%	61%	25%
Drugs	52%	1%	96%	3%
3. Public Health	1%	86%	0%	14%
4. Administration	3%	100%	0%	0%
Total	**100%**	**16.0%**	**70.6%**	**13.3%**

Source: Cashin, 2004

Table 2: Total Health Spending in Tajikistan in 1999 and 2003 (current $US)

Year	**1999**	**2003**
Total Health Expenditure (US$ million)	$45.0	$75.5
Population (million)	6.1	6.5
Per Capita GDP	$171	$200
Per Capita Total Health Expenditure (US$)	$7.40	$11.60
Total Health Expenditure, as % GDP	4.3 %	5.8 %
Government Health Expenditure, as % GDP	1.1 %	0.9 %
Household Expenditure on Health, as % GDP	2.9%	4.1%

Source: Cashin, 2004

The Government's Health Financing Strategy. Recognizing the various problems with health care financing, the Ministry of Health, in collaboration with donors, has developed a Health Financing Policy. The goals of the strategy are to improve equity, efficiency and cost-effectiveness of the health system through health financing reforms. Key directions of reforms proposed in the strategy include:

- Establishment of an institutional structure of a single-payer for health care.
- Pooling of sources of public funds for free health care.
- Development and implementation of new provider payment mechanisms.
- Regulation of informal payments in the health system and introduction of formal co-payments.
- Increasing health personnel salaries.
- Reorganization of the system of health services delivery.
- Improving the quality of health care.
- Increasing public financing for health care.
- Improving donor aid coordination in the health sector.

Based on this strategy, the Government has developed specific programs that would assist with implementation of the Health Care Financing strategy, i.e. per capita financing for PHC and the Basic Program of Medical Care Services (BPMCS).

Per Capita Financing for PHC. The introduction of per capita financing for PHC will help the MOH incrementally move away from input to output-based financing, and provide a better match between needs and resource allocation. The current distribution of financing is highly inequitable with some rayons receiving five times more budget than others on a per capita basis. Steps include the following:

Calculation of the Per capita Rate and Flow of Funds. Currently, there are two main sources of financing for primary care: (i) allocations from the oblast (regional) and rayon (district) health budgets, and (ii) allocations by jamoats. Since oblast and rayon health budgets are insufficient jamoats supply significant supplementary funds in cash and in-kind. During the first stage of implementation of the PHC per capita financing, the Ministry of Finance would take 25 percent of the health budget (current allocations for PHC) and divide by the population, yielding a national PHC per capita rate. This would be multiplied by the population of each rayon, yielding a rayon level per capita budget. Per capita financing is expected to be refined over time (next 2-3 years). For example, coefficients for high mountain areas, age and sex adjusters will also be added in the future (higher payments for women, children and the elderly). Per capita financing for PHC would also be linked to annual budget formulation and the medium-term budget framework and would provide a clear and transparent tool for tracking the Government's allocations for PHC, increasing which is a key element of the government's Poverty Reduction Strategy.

- Status: Concept formally approved by MOF and MOH in March 2005. Implementation steps under discussion, but first steps—i.e. calculation of the national per capita rate and using this as a basis for PHC allocations—are scheduled for January 2006.

Flow of Funds. A treasury sub-account for PHC would be created at the rayon level and the PHC budget for each rayon would flow through this sub-account. Line items under the sub-account will include: salaries, pharmaceuticals, other consumables, and operations and maintenance. Jamoats will continue to make the allocations that they were making before (cash and in-kind contributions).

- Status: Agreement on the sub-account by MOH and MOF, but only for non-salary recurrent expenditure since salaries are a protected item.

PHC Management and Accountability Arrangements. At the rayon level, management responsibilities within the Central Rayon Hospital need to be reorganized to create a department responsible for PHC including the procurement and distribution of pharmaceuticals and other consumables to PHC facilities, collecting data from PHC facilities on productivity and referrals, analyzing this data for variation across the PHC facilities and sharing this data with PHC facilities, Oblast Health Departments and MOH.

- Status: Agreement on the need for a separate department but not yet on how the department will be staffed, i.e. from where in the current system the new PHC directors will be appointed. A decision is expected by December 2005.

Basic Benefit Package. Significant progress has been made in defining and approving a national guaranteed package of basic health services. The BPMCS provides a legal framework for developing the co-payment policy that was legalized with the constitutional referendum in 2003. The Guaranteed Basic Benefit Package provides free services for vulnerable population groups and selected health services. The majority of covered services are in PHC. In hospitals, BPMCS implementation has a different character and supports efforts to formalize informal payments by allowing hospitals to charge for services not covered by the state under the BPMCS (paid services). A two-rayon pilot of BPMCS implementation showed a substantial increase in hospital revenues as a result of BPMCS implementation. In one rayon additional revenues were split 60:40 between operating costs and salary bonuses for hospital staff, with hospital workers' incomes going up as much as 200%. A medium-term objective of the BPMCS is to move hospitals away from budget finance to a combination of budgetary funds and fee revenues from patients. Budgetary funds thus freed would be reallocated to other parts of the health system such as PHC

and public health. But a careless or partial implementation of the scheme could have negative results. If patients are forced to pay formal *and* informal fees, the impact on access and equity would be negative; and if hospitals continue to receive budgetary funds on an input basis rather than on the basis of actual services delivered, efficiency incentives will fail and the country's hospital network will remain oversized, as it is now. Therefore, priorities under BPMCS implementation in the hospital sector include:

- Introduction of output-based purchasing methods (case-based payments). The USAID-funded ZdravPlus Project has already initiated activities in 16 hospitals aimed at developing a simple case-based payments system and a simple computerized information system exists, developed using the experience of neighboring Kyrgyzstan where a similar system is now in place in all hospitals. Data is being collected from hospitals on case mix and cost structure.
- Information dissemination for patients on rights under the BPMCS and opportunities for redress in case of abuse of patients rights, especially as regarding co-payments and fees for paid services.
- Development of hospital business plans that link the different sources of revenues for the hospital (budgetary and non-budgetary) and expected use, to ensure transparency and accountability for funds, as well as linkages to the Government's health sector policies.

Health Information Systems

Post-Soviet health systems share a common legacy of excessive information collection, infrequent information dissemination and limited use of information for management purposes. Tajikistan is no exception. Public sector information systems are weak and the various parallel information systems established by humanitarian agencies provide little in the way of a coordinated or coherent approach to the collection and use information except for their own narrow purposes, e.g. a TB surveillance system for NGOs working on TB control. A MOH-led Working Group on HMIS has met regularly to address these issues over the past year and a Ministerial order in February 2005 called for establishment of a "single framework" for data collection and use in the health sector. Under the Primary Health Care Project, a basic primary care HMIS was developed, introduced in two rayons and used to generate management-friendly reports. The software was simple, had modest hardware requirements and was found to be useful by providers, managers and the Republican Health Information Center. For hospitals, the USAID-funded ZdravPlus project has developed a basic HMIS software package that is currently being piloted in 16 hospitals to collect data on case mix and cost structure, was developed with hospital autonomy in mind and is planned to be adapted to serve billing and receiving functions. This too has been welcomed by hospital managers and the Republican Health Information Center and is planned for review and broader deployment in the coming years. Both packages could also be adapted to include basic surveillance functions, though neither would replace the need for a more fundamental approach to strengthening Tajikistan's disease surveillance system. It is recognized that HMIS development is an area fraught with risk and many HMIS efforts have failed, including in countries richer and with more capacity than Tajikistan. As such, the tactical approach of the present Project involves the introduction of a basic, modest information system designed for key managerial tasks: in this case, managing PHC networks at the rayon level, managing the central rayon hospital and managing an oblast-level single payer for hospital services. The objective is not to introduce a complex, comprehensive or multi-faceted system but rather to approach HMIS development in a step-by-step, modular fashion starting with high-priority tasks and building upward from there. The need to avoid high-cost, high-complexity interventions is also driven by the imperative to keep costs down, given Tajikistan's profound resource constraints.

Annex 2: Major Related Projects Financed by the Bank and/or other Agencies

TAJIKISTAN: COMMUNITY AND BASIC HEALTH PROJECT

Project	Sector Issue	Latest ISR Rating or OED Evaluation Rating for Closed Projects; Implementation Status for non-Bank Projects
Primary Health Care Project	US$5.4 million IDA credit. Focused on PHC development and training; health facilities rationalization and development; health care financing; and capacity building.	Closed in March 2005. ICR rating Satisfactory.
Policy-Based Credit	US$10 million IDA credit with sections o on public sector reform, human development, energy sector and SME development.	Under preparation. To be implemented by MOF.
Central Asia Regional HIV/AIDS Project	US$25 million IDA Grant plus US$1.9 million DfID Grant.	Effectiveness expected in October 2005.
Ongoing		
ADB	Health Sector Reform Project. US$10.5 million credit. Health Reform in GBAO, Khatlon, RRS and Sughd.	2004 to 2009. Implemented by President's Administration.
Aga Khan Development Network	TA grants for health topics including HMIS, nursing development, MCH, pharmaceutical policy, health reform and hospital development, totaling US$1.9 million. Mostly in GBAO.	1998 to 2005. Implemented by AKDN.
CARE Tajikistan	Commodity aid of US$0.7 million for emergency maternal care in Khatlon and RRS.	2000 to 2005. Implemented by CARE Tajikistan.
European Commission	TA grants of US$1.4 million for childhood malnutrition and disease control in RRS and Khatlon.	2000 to 2005. Implemented by EC Directorate General for Humanitarian Aid and Action Against Hunger U.K.
Switzerland/SDC	TA grant of US$2.8 million for health reform and family medicine support under "Tajik-Swiss Health Sector Reform and Family Medicine Support Project", or "Project Sino."	2003 to 2006. Implemented by Swiss Tropical Institute and MOH
Japan/JICA	TA grant of US$1.5 million for "Improving access and quality in Maternal and Child Health Services in Tajikistan."	2004 to 2009. Implemented by UNICEF Tajikistan.

Project	Sector Issue	Latest ISR Rating or OED Evaluation Rating for Closed Projects; Implementation Status for non-Bank Projects
Mercy Corps International	TA grant of US$0.63 million for "Community Empowerment for Health and Water" in Sughd.	2003 to 2005. Implemented by Mercy Corps International.
Save the Children USA	TA grant of US$6.5 million for "Expanding MCH and RH services" in Khatlon oblast.	2002 to 2007. Implemented by Save the Children USA.
UNDP	TA grant of US$1.4 million to "Support to Strategic Plan of the National Response to HIV/AIDS" for high-level policy makers.	2003 to 2005. Implemented by UNDP.
UNFPA	TA grant of US$1.4 million to strengthen RH services in Tajikistan.	2000 to 2005. Implemented by UNFPA.
UNICEF	TA grant of US$5.9 million for Mother and Child Survival, Development and Protection.	2000 to 2005. Implemented by UNICEF.
USAID	TA and commodities grant of US$6 million for control of infectious diseases nationwide.	2000 to 2007.
	TA grant of US$5.4 million for MCH, RH and child survival in Dushanbe, GBAO, Khatlon, RRS and Sughd	2000 to 2007.
	TA grant of US$3 million for health sector reform support under now-renewed ZdravPlus program.	1998 to 2005.
WHO	Annual collaborative agreements that cover *inter alia* health reform, infectious diseases, emergency preparedness and pharmaceutical policy.	Renewed annually.

Annex 3: Results Framework and Monitoring

TAJIKISTAN: COMMUNITY AND BASIC HEALTH PROJECT

Project Development Objective	Project Outcome Indicators	Use of Project Outcome Information
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.	Decrease in percentage of households in project-supported areas who don't seek health care when necessary because they can't afford it (baseline, 2003 ~57% of poor households). Decrease in share of health in household expenditure in project areas (baseline, 2003 > 9%). More equitable distribution of the health budget through implementation of per capita financing in PHC and case-based payment for hospitals. Improvement in PHC infrastructure, services and patient satisfaction in project areas.	Project Evaluation

CBHP Component A: Strengthening Policy, Planning, and Donor Coordination in the Ministry of Health		
Project Development Objective	**Project Outcome Indicators**	**Use of Project Outcome Information**
MOH shows increased coherence and coordination in policymaking, policy analysis and management of donor support.		
Intermediate Outcomes	**Intermediate Outcome Indicators**	**Use of Intermediate Outcome Monitoring**
A1: Policy Formulation and Analysis MOH policy is based to a greater extent on demonstrated needs of the population and evidence of policy/reform impact.	Stage of development of Health Policy Analysis Unit in MOH Department for Planning, Coordination and Implementation of Health Reforms: a.) furnishing b.) staffing c.) training d.) actively performing duties Completion by HPAU of: a.) baseline and 2 follow-up	Ensure timely progression of steps necessary for HPAU functioning. (PIU) Track progress in HPAU's ability to provide evidence-based advice

	surveys of: public expenditure tracking, out-of-pocket payment, client satisfaction, others as needed b.) National Health Accounts (with MOH Economic and Financial Planning unit) c.) basic sector MTBF, following completion of sector strategy	to MOH, determine whether additional TA needed. (PIU)
	Number of requests from MOH for advice/ data/ other reports from HPAU in 6 month period.	Gauge whether MOH is taking advantage of new services provided by HPAU. (PIU)
	Percentage of MOH requests fulfilled by HPAU within requested time period.	Identify possible roadblocks to MOH use of HPAU information. (PIU)
A2: Strategic and Operational Planning Departments and working groups within MOH show greater coordination and coherence in their efforts.	Stage of development of Working Group Secretariat: a.) furnishing b.) staffing c.) actively performing duties	Ensure little delay in needed support for working groups. (PIU)
	Number of subsectoral strategies for target working groups: a.) completed b.) approved by MOH c.) in implementation phase	Identify working groups in need of TA. (PIU)
	Average # of working groups represented at interdepartmental health coordination meetings.	Monitor level of coordination between sub-sectors, increase incentives if necessary. (PIU)
	Stage of development of overall sector strategy: a.) provision of stakeholder input b.) completion of strategy c.) approval by MOH d.) implementation	Ensure timely completion of sector strategy, provide TA as needed. (PIU)
A3: Donor and Policy Coordination MOH, other government bodies, and donor community show greater coordination in addressing needs of health sector.	Average # of working groups, organizations represented at biannual sector conferences.	Gauge donor community's buy-in to sector coordination, adjust conference/publicity planning accordingly. (PIU)

A4: Public Relations and Communication The general population and MOH staff have a better understanding of MOH's reform efforts.	Stage of development of PR strategy: a.) provision of stakeholder input b.) review of public information environment c.) completion of strategy d.) approval by MOH e.) implementation Percentage of population, health providers and MOH staff with basic understanding of essentials of BPMCS and per capita financing reforms.	Monitor strategy development, provide TA as needed. (PIU) Focus PR strategy on identified needs. (HPAU)

CBHP Component B: Implementing Organization and Financing Reforms in the Health Sector		
PDO	**Project Outcome Indicators**	**Use of Project Outcome Information**
Increased capacity and efficiency at oblast and rayon levels in health sector management and progressive implementation of per capita financing and the BPMCS.	Health expenditure as share of household expenditure in project-supported areas (baseline, 2003 > 9%). Ratio of population-adjusted PHC funding between the least- and most-funded rayons in project-supported areas (baseline ~ 5).	Evaluate project effectiveness in decreasing out-of-pocket payments, identify areas where reforms least effective, target resources accordingly. (HPAU) Evaluate implementation of per capita financing, identify areas where reforms least effective, target resources accordingly. (HPAU)
Intermediate Outcomes	**Intermediate Outcome Indicators**	**Use of Intermediate Outcome Monitoring**
B1: Strengthening PHC Management and Financing Oblast and rayon level management of PHC strengthened, streamlined.	Number and location of project-targeted oblast PHC depts., rayon PHC depts., rayon hospital services depts.: a.) furnished b.) staffed c.) trained d.) actively performing duties Stage of development of PHC HMIS for utilization tracking and basic disease surveillance: a.) review/evaluation b.) development c.) training d.) active usage in oblast and rayon PHC depts.	Identify depts. lagging behind in development, identify and address roadblocks. (PIU) Ensure timely development of HMIS. (PIU)

B2: Strengthening Hospital Management and Implementing the BPMCS Oblast and rayon level hospital management strengthened and BPMCS implemented.	Number of PHC cases per capita entered into HMIS. Stage of development of BPMCS-supporting HMIS for hospitals and oblast health depts.: a.) review/evaluation b.) development c.) training d.) active usage in hospitals and oblast PHC depts. Number of hospital patient cases per capita entered into HMIS. Percentage of population in project-supported areas with basic understanding of their rights under BPMCS and opportunities for redress.	Measure level of HMIS use/training effectiveness, determine whether further training needed. (HPAU) Ensure timely completion of HMIS. (PIU) Measure level of HMIS use/training effectiveness, determine whether further training needed. (HPAU) Focus PR strategy on identified needs. (HPAU)
B3: Strengthening MOH Oversight of Organizational and Financial Reforms Economic and Financial Planning unit of MOH shows increased capacity for output-based budget formulation and hospital policy development.	Stage of development of MTBF, National Health Accounts: a.) training b.) research/data collection c.) drafting d.) completion/ review by MOH e.) approval	Track progress in milestone activities, determine whether additional TA needed. (PIU)

CBHP Component C: Strengthening Primary Health Care in Selected Rayons		
PDO	**Project Outcome Indicators**	**Use of Project Outcome Information**
To increase access to, utilization of, and patient satisfaction with primary health care services in project-supported areas. ***NOTE: C2 Parallel-financed by Sida**	# of visits to PHC facilities by children and women of childbearing age. % of 1-year-old children covered by measles (MDG indicator), DPT-3 and Polio-3 immunizations. % of births attended by skilled health personnel (MDG indicator).	Evaluate project effectiveness in increasing utilization; identify target areas for resources. (HPAU) Evaluate project effectiveness in increasing utilization; identify target areas for resources. (HPAU) Evaluate project effectiveness in increasing utilization; identify target areas for resources. (HPAU)

	Ratio of inhabitants per project-trained family doctor in project-supported areas. Patient satisfaction with PHC services in project-supported areas.	Evaluate project effectiveness at increasing access; identify target areas for resources (HPAU). Evaluate project effectiveness at increasing patient satisfaction; identify target areas for resources (HPAU).
Intermediate Outcomes	**Intermediate Outcome Indicators**	**Use of Intermediate Outcome Monitoring**
C1: Strengthening the PHC Infrastructure PHC infrastructure in selected rayons renewed.	Stage of development of standard design packages for rural health facilities: a.) awaiting contract b.) information gathering c.) development d.) completion/ review by MOH e.) approval Percentage of project-targeted PHC facilities for which civil works are at following stages of development: a.) design phase b.) design approved c.) civil works ongoing d.) civil works completed e.) facilities receiving patients	Ensure timely completion of packages. (PIU) Monitor progress of civil works, identify and address possible roadblocks. (PIU)
C2: Strengthening PHC Services and Outreach (parallel-financed by Sida) Relationship between health workers and communities is strengthened.	% of communities in project-targeted areas completing: a.) Participatory Rural Assessment b.) program of targeted interventions c.) grant proposals Grant funds disbursed (USD).	Gauge progress in community-health worker dialogue, direct resources as needed. (Sida) Ensure progress of small grants program, identify and address possible roadblocks. (Sida)
C3: Strengthening PHC Training Health workers have improved skills in the area of PHC.	# and location of doctors and nurses trained under national PHC training plan.	Monitor progress of PHC training, adjust location of training if needed. (HPAU) Determine areas of greatest need for training. (HPAU)

Arrangements for results monitoring

		Target Values					Data Collection and Reporting		
	Baseline	**YR1**	**YR2**	**YR3**	**YR4**	**YR5**	**Frequency and Reports**	**Data Collection Instruments**	**Responsibility for Data Collection**
Project Outcome Indicators									
Decrease in percentage of households in project-supported areas who don't seek health care when necessary because they can't afford it	57% (2003)	57%				47%	Pre/Post Project	Household surveys	MOH Department for Reform Coordination, Health Policy Analysis Unit
Decrease in share of health in household expenditure in project-supported areas	9% (2003)	9%				6%	Pre/Post Project	Household surveys	MOH Department for Reform Coordination, Health Policy Analysis Unit
More equitable distribution of the health budget through implementation of per capita financing in PHC and case-based payment for hospitals.	Nil of 41 rayons in Sughd and Khatlon	0	12	41	41	41	Biannual	PIU reports, annual reports of MOH, oblast health departments, central rayon hospitals and rayon PHC departments.	MOH Department for Reform Coordination, Health Policy Analysis Unit
MOH, other government bodies, and donor community show greater coordination in addressing needs of health sector.	No regular, formal coordination forums: e.g. Health Summits	2 summits	2	2	2	2	Biannual	PIU reports, annual reports of MOH, National Board on Health, Aid Coordination Unit of President's Administration, donor organizations	PIU
Community at large gains better understanding of MOH's reform program and higher satisfaction with health services.	Pending					Baseline plus 20 percent	Annual	Household surveys, focus groups	MOH Department for Reform Coordination, Health Policy Analysis Unit

		Target Values					Data Collection and Reporting		
	Baseline	**YR1**	**YR2**	**YR3**	**YR4**	**YR5**	**Frequency and Reports**	**Data Collection Instruments**	**Responsibility for Data Collection**
MOH's capacity in area of hospital policy development strengthened.	Three trained staff	4 staff	5	6	7	8	Biannual	PIU reports, MOH reports	PIU
Community benefits from improved PHC infrastructure, services, and outreach at community level.	0 facilities {**nb**. Will also measure utilization of PHC through pre and post HHS}	0 facilities	6	30	45	50	Biannual	Site visits, PIU reports	PIU
Intermediate Outcome Indicators									
Health Policy Analysis Unit established in MOH. HPAU monitors and evaluates health reforms, provides MOH with evidence-based advice.	Not established	Established	Cont.	Cont.	Cont.	Cont.	Biannual	PIU reports, annual reports of MOH, HPAU	PIU, HPAU, MOH Department for Reform Coordination
MOH renews and develops sector strategy and subsectoral strategies with inclusion of key national and international partners.	Broad strategy exists, but not updated in >3 years; 2 subsector strategies		2 new sub-sector strats.		3 new sub-sector strats.		Biannual	PIU reports, MOH annual reports	MOH Department for Reform Coordination
MOH, other government bodies and donor community brought together for biannual sector review conferences to review progress and jointly plan efforts.	Nil	2 summits	2	2	2	2	Biannual	PIU reports, annual reports of MOH, National Board on Health, Aid Coordination Unit of President's Administration, donor organizations	PIU
MOH's public relations capacity strengthened.	One trained staff member.	2 staff		3		4	Annual	Annual reports of MOH, consultant evaluations	PIU

		Target Values					Data Collection and Reporting		
	Baseline	YR1	YR2	YR3	YR4	YR5	Frequency and Reports	Data Collection Instruments	Responsibility for Data Collection
Calculation and implementation of per capita financing in PHC.	Nil of 41 rayons in Sughd and Khatlon	0	12	32	41	41	Biannual	PIU reports, annual reports of MOH, oblast health departments, central rayon hospitals.	MOH Finance Department, Health Policy Analysis Unit
Management and finances of PHC separated from that of the hospital at the rayon level.	Combined	Done					One-off	Annual reports of central rayon hospitals and rayon PHC departments.	MOH Finance Department, Health Policy Analysis Unit
Rayon PHC Departments strengthened with management training, furniture, computers, equipment and development of PHC management information system for utilization tracking and basic disease surveillance.	Nil of 41 rayons in Sughd and Khatlon	0	20	41	41	41	Biannual	PIU reports, annual reports of MOH, oblast health departments, central rayon hospitals and rayon PHC departments.	PIU
Rayon PHC management benefit from TA and on-the-job training/supervision provided by oblast health departments.	Nil of 41 rayons in Sughd and Khatlon	0	20	41	41	41	Biannual	PIU reports, annual reports of oblast health departments, rayon PHC departments.	PIU
Rayon hospital accounts departments trained for role as collector of fee revenues, provided with furniture, computer and software.	Nil of 41 rayons in Sughd and Khatlon	0	20	41	41	41	Biannual	PIU reports, annual reports of rayon PHC departments.	PIU
Oblast health departments trained to process hospitals' BPMCS payment claims, provided with computers, servers, software and IT consultants.	Nil of 2 OHDs in Sughd and Khatlon	Both OHDs	Cont.	Cont.	Cont.	Cont.	Biannual	PIU reports, annual reports of oblast health departments.	PIU

		Target Values					Data Collection and Reporting		
	Baseline	**YR1**	**YR2**	**YR3**	**YR4**	**YR5**	**Frequency and Reports**	**Data Collection Instruments**	**Responsibility for Data Collection**
General public better informed about their rights under BPMCS and opportunities for redress in cases of abuse through radio spots, newspaper advertisements, etc.	Sporadic public information efforts by MOH	Quarterly public information efforts	Cont.	Cont.	Cont.	Cont.	Biannual	Annual reports of PIU and MOH; houschold surveys, focus groups	PIU, Health Policy Analysis Unit
MOH capacity to track community satisfaction and the effectiveness of public expenditure improved through community surveys, PETS.	Nil	First patient satisfaction survey	First PETS	Second patient satisfaction survey	Second PETS	Third patient satisfaction survey	Biannual	PIU reports, annual reports of MOH, HPAU	MOH Department of Reform Coordination, Health Policy Analysis Unit
MOH capacity to link strategic objectives with budget allocations strengthened through development of MTBF that reflects sector and subsector strategies and increased emphasis on PHC and the BPMCS.	No MTBF			First Test MTBF	First full sector MTBF		Biannual	PIU reports, annual reports of MOH, HPAU	MOH Finance and Reform Coordination Depts., Health Policy Analysis Unit
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.	Nil (PHRD)	Done					One-off	PIU reports	PIU
At least 50 PHC facilities in two rayons in Sughd and Khatlon oblasts rehabilitated or replaced.	Nil	0 facilities	6	30	45	50	Biannual	PIU reports, site visits, annual reports of rayon PHC departments	PIU
Regular dialogues commenced and ongoing between health workers and communities to identify service delivery bottlenecks and prioritize solutions.	Nil {**nb**: this activity will be done in parallel by Sida}						Biannual	PIU reports, site visits, annual reports of rayon PHC departments	PIU

		Target Values					Data Collection and Reporting		
	Baseline	YR1	YR2	YR3	YR4	YR5	Frequency and Reports	Data Collection Instruments	Responsibility for Data Collection
All PHC workers in project rayons retrained under approved family medicine training scheme.	Nil of 6 pilot rayons in Sughd and Khatlon	60 doctors, 126 nurses	116 doctors, 252 nurses	172 doctors, 376 nurses	176 doctors, 496 nurses	176 doctors, 496 nurses	Biannual	PIU reports, MOH annual reports, site visits, annual reports of rayon PHC departments	PIU
Establishment of Project Implementation Unit consisting of director, finance officer, procurement officer and procurement assistant.	Pending	Done	Cont.	Cont.	Cont.	Cont.	Biannual	PIU reports	PIU
Field supervisors hired as local consultants to oversee civil works.	Nil	Done	Cont.	Cont.	Cont.	Cont.	Biannual	PIU reports	PIU
Comprehensive project monitoring reports submitted twice a year.	Two per year	2	2	2	2	2	Biannual	PIU reports	PIU

Annex 4: Detailed Project Description

TAJIKISTAN: COMMUNITY AND BASIC HEALTH PROJECT

The project has the following 4 components:

A. Strengthening Policy, Planning and Donor Coordination in the Ministry of Health[6] (US$1.46 million baseline cost)

Basic facts:

- Objective: Strengthening MOH capacity for policy analysis, strategy formulation, donor coordination and public relations.
- Principal Beneficiary: Ministry of Health
- Stakeholders: MOF, President's Administration, Health Donors, General Public
- Key partnerships: WHO/EURO for A1, USAID-funded ZdravPlus, SDC-funded Project Sino, WHO, UNICEF, ADB
- Key linkages with other operations: Groundwork for proposed Health SWAp in 2009
- Estimated cost: $1.5 million baseline cost

This component would strengthen coherence and coordination in policymaking, policy analysis and the management of donor support by MOH. The component would support four streams of activity.

A1. Policy Formulation and Analysis. This subcomponent would support the establishment of a Health Policy Analysis Unit in MOH. The HPAU would consist of three local consultants based in the Ministry of Health under the MOH's Department for Planning, Coordination and Implementation of Health Reforms. The Unit would be supported by one long-term international consultant with expertise in monitoring and evaluation and implementation of health reforms. The HPAU would perform the following analytical functions:

- Monitoring and evaluation of health reforms, concentrating initially on implementation of reforms in primary care and implementation of the Basic Benefit Package;
- Provision of evidence-based advice on policy development in response to MOH needs.

The subcomponent would finance workshops and surveys—including client satisfaction surveys, public expenditure tracking surveys and out-of-pocket payment surveys—designed to complement the reforms being implemented under Component B. It would also finance "milestone" activities such as National Health Accounts and functional and legislative reviews of the health sector. A basic sector MTBF would be developed later in project implementation, once a sector strategy has been agreed on. These activities would be carried out by MOH in conjunction with international consultants as required and would be coordinated by the HPAU. The subcomponent would also finance training, study tours and limited operating costs for the unit.

[6] In keeping with the "one room, many doors" approach of the Tajikistan Country Assistance Strategy, this section describes not only activities being financed by the Community and Basic Health Project but also relevant activities covered by other Bank operations such as the proposed Policy Based Credit (FY2006/7) and, later, the proposed Poverty Reduction Strategy Credit (FY2007/2008). This is especially relevant for activities in health financing and management, such as those in Component B, which rely equally on investment support and on policy reforms such as those supported by development policy lending.

A2. Strategic and Operational Planning. This subcomponent would help build MOH's capacity for strategic planning and for ensuring coherence between sub-sectors. It would do so by helping MOH strengthen and operationalize a comprehensive sector strategy, primarily by financing workshops and a small number of local consultants. The strategy would be based on subsectoral strategies—some of which, such as the health financing and HMIS strategies, already exist—and would collect these into a coherent overall strategy through a technically-guided process with transparency and full inclusion of key national and international partners. This would not only improve the coherence of sector policies but also provide a basis for improving coherence in donor-financed activities and a step toward implementing a Sector-Wide Approach or "SWAp" in the Tajikistan health sector in future. The subcomponent would finance workshops, seminars, etc. to support preparation of the sector strategy. The international advisor hired under A1 would support this process as well, though it is expected that most of the conceptual work would be managed by MOH staff and local consultants with technical input from resident donors and agencies. Limited funds would be made available for international consultants as required.

A3. Donor Coordination. This subcomponent would help MOH improve donor coordination by financing biannual sector review conferences that would also include high-level government coordination bodies such as the National Board on Health under the Prime Minister's Office and the Aid Coordination Unit in the President's Administration. These would bring together MOH and the donor community for a review of strategies, priorities and modes of support and a review of progress in the health sector. The agenda would include a review of progress in the preceding six months, a report on new developments in the sector and an opportunity for joint planning for the six months ahead. These would provide an opportunity for collective policy analysis, a means of communicating policy objectives and, critically, a way of improving coordination between government actors and between the government and international donors. The component would finance meeting costs only; the responsibility for organizing the event would rest with MOH itself, drawing on PR and M&E consultants for help with logistics and substance as required. Funds to procure short-term logistical support for organizing the summits may also be included.

A4. Public Relations and Communication. This subcomponent would strengthen the public relations capacity of the MOH by providing a small budget for PR activities, communication programs etc. A PR unit has recently been established with support from USAID-funded ZdravPlus Project to help manage PR efforts connected with the MOH's overall reform program, especially the introduction of per capita financing and the Basic Benefit Package. To support this, operating costs would be provided and an international consultant would be hired to help develop a communication strategy for MOH and periodically oversee PR developments. This would take into account similar work currently taking place under the ADB health project and a recently-announced one-year initiative sponsored by WHO to help improve day-to-day donor coordination in MOH through a website, newsletters, etc.

B. Implementing Organizational and Financing Reforms in the Health Sector (US$4.29 million baseline cost)

Basic facts:

- Objective: Supporting the introduction of per capita financing and a basic benefit package of health services in Sughd and Khatlon oblasts through management strengthening for oblast/rayon health departments and PHC/hospital managers and provision of furniture, equipment and basic IT systems.
- Principal Beneficiaries: Ministry of Health (Reform Coordination, Economic and Financial Planning Units), Oblast Health and Finance Departments (2: Sughd and Khatlon), Rayon Health Departments (41: All Rayons in Sughd and Khatlon), and populations of Sughd and Khatlon oblasts (~3.2 million).
- Stakeholders: MOH, Oblast/Rayon Administrations, Donors, Populations of Sughd and Khatlon.

- Key partnerships: USAID-funded ZdravPlus, SDC-funded Project Sino.
- Key linkages with other operations/activities: PBC conditionalities expected to lay the groundwork for per capita financing and PHC reforms [see below for details]; governance reforms supported by PBC and others on per capita financing in the social sectors and by USAID/Urban Institute and others on decentralization of fiscal responsibility and accountability [B1 strengthens rayon accountability for PHC by introducing professional PHC management to the rayon; B2 strengthens oblast oversight of hospital services by introducing the purchasing function; B1 and B2 clarify fiscal responsibilities at each level, and for each kind of service].
- Estimated cost: $4.3 million baseline cost.

This component would support the implementation of per capita financing for primary health care and implementation of the Basic Benefit Package. This will require two streams of activity—one in PHC and one in hospitals—and will be carried out initially in the 41 rayons of Sughd and Khatlon oblasts (total population: 3.2 million). It will also require capacity building in the Economic and Financial Planning Unit of MOH. Three subcomponents are envisaged:

B1. Strengthening PHC Management and Financing. With the introduction of per capita financing and the government's intention to strengthen PHC more generally, the management of PHC services at the rayon level will need to be made distinct from that of hospitals. At present this relationship is mixed; some PHC services are financed by rayon budgets and reporting to the Director of the Central Rayon Hospitals, while others are financed by local contributions at lower levels. PBC will support a number of measures designed to improve the coherence of PHC management and financing and enable the effective implementation of per capita-based budgeting for PHC. These include the following: administrative separation of PHC from hospitals at the rayon level; a treasury account for PHC at the rayon level, separate from that of the CRH; collection of all PHC facilities—and their per capita based budgets—under the authority of a rayon-level PHC department and manager in a so-called "network" model; and adoption of per capita budgeting for calculating and distributing rayon PHC budgets. Rayon-level PHC managers will be responsible for managing the network of PHC facilities under their charge, including their per capita based budgets, perhaps with a moderate degree of budgetary autonomy to allow for the provision of staff incentives and for higher expenditure in hard-to-reach, needy or poor areas of their rayon. These measures will ensure that PHC funds are distributed equitably across the population, are protected from diversion to other parts of the health system and are better matched to actual needs. They will also provide the foundation for an approach to PHC management at the rayon level that will promote greater coherence and the ability to accommodate an expanded focus on community outreach and basic public health. But policy measures will not be sufficient alone; support for implementation will also be required. Three steps are required, support for which will come from both the PBC and the Project. These are:

- Calculating the Per Capita Rate. ***This would primarily be supported by the PBC***. Background: There are currently two main sources of financing for primary care: 1. Allocations from the oblast and rayon health budgets, and 2. Allocations by Jamoats. Since oblast and rayon health budgets are insufficient, Jamoats supply significant supplementary funds in cash and kind. During the first stage of implementation of PHC per capita financing, MOF would take 25 percent of the consolidated health budget—i.e. the current allocation for PHC—and divide this by the total population, yielding a national PHC per capita rate. This would be multiplied by the population in each rayon, yielding a rayon level per capita budget to replace current input-based rayon PHC budgets. Allocations for each facility would be determined by a newly-formed rayon PHC department. To begin with this would follow existing norms; in time, however, it would evolve into an allocation based on the catchment area for each facility and would be refined through the addition of adjusters for high mountain areas and for the age and sex distribution of the covered population. The size of the overall PHC budget would be determined as part of the annual budget formulation process and would be reflected in the

MTBF. This would provide a clear and transparent means of tracking the government's allocations to PHC, increasing which is one of the government's PRSP objectives.

- Flow of Funds. ***This would primarily be supported by the PBC.*** Background: To separate PHC financing from that of hospitals would require *inter alia* the creation of a separate treasury sub-account for PHC at the rayon level. The per capita-based PHC budget will flow through this sub-account rather than being admixed with that of the Central Rayon Hospital. Line items under the sub-account would include salaries, pharmaceuticals, other consumables, and operations and maintenance. Jamoats will still have the freedom to make cash and in-kind contributions directly to facilities.

- PHC Management and Accountability Arrangements. ***This would primarily be supported by the Project.*** At the rayon level, management responsibilities under the Director of the Central Rayon Hospital—currently the ranking manager of all health services in the rayon—will be reorganized in two subsets: a Department of Primary Health Care, and a separate Department of Hospital Services. Each would be headed by a Deputy Director, and both would report to the Director of the CRH. The newly-formed PHC Department would be responsible for all aspects of PHC, including procurement and distribution of pharmaceuticals and other consumables to PHC facilities, collecting data from PHC facilities on productivity and referrals, analyzing this data for variation across the PHC facilities, sharing this data with PHC facilities and higher bodies, and coordinating referrals and patient care with the hospital system. Most importantly, s/he would control the PHC sub-account and ensure these funds are indeed spent on PHC. Oversight would come from the oblast health department in the form of help with data collection and interpretation and management "coaching" for 2-3 years until the rayon PHC departments mature.

The subcomponent would help build capacity among the newly-formed rayon PHC Departments to manage the network of facilities in their charge. Specific inputs would include management training, furniture and computers for rayon PHC Departments in 41 rayons in Sughd and Khatlon oblasts; development of a basic rayon-level PHC management information system for utilization tracking and basic disease surveillance; procurement of an outreach vehicle for each rayon unit to permit supervisory visits to subordinate clinics in the rayon; and local consultants to be recruited by oblast health departments as "PHC coaches" following the Tendler and Freedheim model of Céara, Brazil. These activities will build on existing work rather than commissioning activities de novo, including use of management training curricula developed by the USAID-financed ZdravPlus Project, and HMIS work done by ADB, ZdravPlus and Project Sino.

B2. Strengthening Hospital Management and Implementing the Basic Program of Medical Care Services. Progress has been made in defining and approving a national guaranteed package of basic health services. The BPMCS provides a legal framework for developing the co-payment policy that was legalized with the constitutional referendum in 2004. The BPMCS provides free services for vulnerable population groups and for selected health services. The majority of covered services are in PHC; in hospitals, BPMCS implementation has a different character and will involve moves to formalize informal payments by allowing hospitals to charge for services not covered by the state under the BPMCS: so-called "paid services". A two-rayon pilot showed a substantial increase in hospital revenues as a result of BPMCS implementation. In one rayon, additional revenues were split 60:40 between operating costs and salary bonuses for hospital staff, with hospital workers' incomes increasing as much as 200%. A medium-term objective of the BPMCS is to move hospitals away from budget finance to a combination of budgetary funds and fee revenues from patients. Budgetary funds thus freed would be reallocated to other parts of the health system such as PHC and public health. But a careless or partial implementation of the scheme could have negative results. If patients are forced to pay formal *and* informal fees, the impact on access and equity would be negative; and if hospitals continue to receive budgetary funds on an input basis rather than on the basis of actual services delivered, efficiency incentives will fail and the country's

hospital network will remain oversized, as it is now. Priorities under BPMCS implementation as related to the hospital sector include the following:

- At the hospital level. The subcomponent would provide furniture, computer and basic software for hospital accounts departments and training for their new role as an active collector of fee revenues and case-based payments vs. a passive recipient of input-driven budgetary funds. A basic HMIS software package has been developed by USAID-funded ZdravPlus and is currently being piloted in 16 hospitals, collecting data on case mix and cost structure. The software was developed with hospital autonomy in mind and could be adapted to serve billing and receiving functions. This would avoid the need for developing a system from scratch. The subcomponent would also help develop business plans that link revenue sources for the hospital, both budgetary and from paid services, with their expected use. This would help ensure transparency and accountability for funds. [Note: A PBC conditionality that sets general parameters for the use of revenues from paid services is also being considered. This might include parameters on salaries and bonuses, operations and maintenance, and establishment of reserve funds.]

- At the oblast level. The subcomponent would support the introduction of a purchasing function in the oblast health department—as anticipated by the recently-passed Health Finance Strategy—and would provide the unit with management training, computers and a server to receive and process hospitals' payment claims for services and individuals covered under the BPMCS. Software for this function would likely be developed *de novo* but would be made complementary to an existing hospital MIS. Provisions would also be made for periodic and in-service training of oblast staff, probably in conjunction with counterparts in MOH, and for hiring of local IT consultants to maintain servers and provide IT support. The subcomponent would also support the oblast health department to disseminate information to patients on their rights under the BPMCS and create opportunities for redress in cases of abuse, especially regarding co-payments for paid services. This would include local and international TA for developing radio spots and advertisements in newspapers, the provision of continuous information on fees and patients' rights, and the establishment of an oblast-level hotline for complaints. These would be linked with the PR activities to be supported in Component A4.

B3. Strengthening MOH Oversight of Organizational and Financial Reforms. This subcomponent would strengthen hospital policy development in the Economic and Financial Planning unit of MOH. Specific tasks would include: 1. 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; 2. Applying output-based budget formulation to the development of the Medium-term Budget Framework and the annual budget process; and 3. Monitoring health financing indicators with the objective of developing a baseline National Health Accounts. The unit would work closely with the HPAU envisaged under Component A in carrying out community surveys and PETS, with survey-related costs financed by the project.

C. Strengthening Primary Health Care in Selected Rayons (US$8.06 million baseline cost)

Basic facts:

- Objective: Strengthening PHC infrastructure (C1), service delivery (C2) and clinical quality (C3) in Sughd and Khatlon oblasts (C1 and C3 in 2-4 rayons, C2 in whole of Sughd and Khatlon).
- Principal Beneficiaries: MOH, Rayon Health Departments, Populations of Sughd and Khatlon.
- Stakeholders: MOH, Rayon Administrations, Donors, Front-line health workers (feldshers, community nurses), Populations of Sughd and Khatlon.
- Key partnerships: UNICEF, SDC-funded Project Sino, NGOs.

- Key linkages with other operations: Development of revised technical norms and standard design packages will promote consistency across government and all donors viz. PHC rehabilitation; this has not been the case to date.
- Estimated cost: $8.1 million baseline cost.

This component would help renew the PHC infrastructure in 2-4 rayons in Sughd and Khatlon oblasts and would support complementary measures to improve service delivery and outreach, including training for health workers and efforts to link health workers and communities more effectively through community involvement and outreach at the PHC level.

C1. Strengthening the PHC Infrastructure. This subcomponent would rehabilitate or replace PHC facilities in 2-4 rayons in Sughd and Khatlon oblasts. The selection of rayons will be based on a PHC rationalization plan currently being prepared with financing from the PHRD grant and would use complementary information from a recent health facilities survey. Criteria for rayon selection would include *inter alia* population size and access issues and the current state of the rayon's health infrastructure. The PHRD grant is also financing a review of building standards and norms in Tajikistan to help develop revised standards that take into account cost- and space-efficiency, comfort and functionality. These in turn are being informed by the PHC rationalization plan and its summary of services to be delivered and HR requirements in primary care. A separate consultancy—also being carried out under the PHRD grant—is developing standard design packages for rural health facilities, including additional packages for photovoltaic energy supply, water supply, disposal of wastewater and handling and processing of solid waste. The subcomponent would finance civil works, furniture and equipment and radio-telephone equipment for the facilities and consulting services for project supervision in the form of an engineer/architect and field coordinators for the PIU.

C2. Strengthening PHC services and outreach. {This subcomponent to be financed in parallel by Sida.} A weakness of the current PHC system is the lack of engaged dialogue between PHC providers and the communities they serve. This is problematic in a country where IMR, U5MR and MMR are high, and where many bottlenecks to service delivery could be relieved with greater attention to the PHC-community interface. To promote this dialogue and improve PHC services in project rayons, this subcomponent would finance two things: first, a process of technically-guided dialogue, prioritization and micro-planning between health workers and communities; and second, a small grants program to back it up. Health workers and communities would be brought together periodically for three years to identify service delivery bottlenecks and prioritize solutions. This would initially be guided by external agents—e.g. a firm or NGO with experience of the health sector, community mobilization and small grants programs—but these agents would be progressively joined by staff from the rayon PHC department in order to build supervision capacity on their part. The objective would be to broker a technically-grounded dialogue on priority health needs and how to address them. Key players would be health workers—including those at levels lower than the SUB, i.e. community nurses and feldshers—and village health committees or similar community structures. Where possible, existing community structures will be used for this purpose. Communities could also receive small grants to 'unblock' the issues in question, e.g. to capitalize a revolving fund, drill a well for the village or fix the road to the health center. TORs for the external agents and the grant selection process and an operational manual could be developed under the PHRD grant or the PPF. The prioritization process would not be over-specified; it would allow communities to take a multi sectoral view of health and use their grants accordingly but would also need to explicitly consider issues of child and maternal mortality and access to pharmaceuticals. The list of activities could include the following:

- Establish an institutional structure for consultation and action on health issues at the village level (e.g. village health committee, village health volunteer) or use existing such structures where possible (e.g. village women's committees, village councils etc.).

- Using local consultants in conjunction with front-line health staff—feldshers, community nurses and PHC clinic providers—carry out an iterative process of technically-guided consultation on priority health issues and the means required to solve them, using a structured approach and progressively institutionalizing these activities in the work of front-line health staff, and commending with some form of Participatory Rural Assessment or Participatory Community Assessments (PRA/PCA).
- Using the same consultants and front-line staff, carry out a well-planned program of health education that improves the community's knowledge and information about key health and nutrition issues, using a structured approach and progressively institutionalizing these activities in the work of front-line health staff.
- Using the same consultants and front-line staff, design a program of targeted interventions for vulnerable groups and priority health issues, e.g. women and children, access to primary care, access to safe delivery and access to pharmaceuticals, focusing equally on health education and on identifying bottlenecks to service delivery.
- Based on the bottlenecks identified during community consultations, and using the same consultants and front-line staff, jointly—i.e. between communities and health workers—develop proposals for remedial actions that can be financed with small grants of <$500; and establish a fair, transparent and technically-grounded appraisal and selection process for the provision of these grants, including reasonable requirements for matching funds.
- Starting in Year 2 and continuing thereafter, work with newly-established rayon PHC departments to jointly translate the activities outlined above into an outreach and health education program that can be implemented and sustained by the PHC departments themselves, drawing on the experience of NGO health promotion/health education activities in Tajikistan, the curricula and approaches advocated by UNICEF and other large donors, and the resources and preferences of rayon-level PHC providers and their managers for such a program.

C3. Strengthening PHC training. This subcomponent would, at a minimum, finance re-training of all PHC workers in project rayons under an approved family medicine training scheme. Given the chaotic state of health worker training in Tajikistan, it will be essential to identify an approach to health worker training that is transparent in nature, avoids duplication, is sustainable, responds to the country's priority health needs and its capacity for training and is agreed across multiple donors.

D. Project Coordination and Capacity Building for Implementation (US$0.62 million baseline cost)

This component (estimated cost: US$0.62 million baseline cost) would finance a Project Implementation Unit consisting of a Director, Deputy Director, Financial Management Specialist, Procurement Specialist, Procurement Assistant, Chief Accountant, Cashier, Legal Advisor, Office Manager and Assistant, Translator, drivers and other auxiliary staff. Field supervisors would be hired as local consultants to oversee civil works. As opposed to the previous project, component specialists in the new project would be co-located with their counterparts in MOH. The PIU would also, over time, 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. Further details are provided in Annex 6.

Annex 5: Project Costs

TAJIKISTAN: COMMUNITY AND BASIC HEALTH PROJECT

Tajikistan
Community and Basic Health Project
Components Project Cost Summary

	(US$) ('000's)		
	Local	Foreign	Total
A. A. Strengthening Policy, Planning and Donor Coordination			
1. A1. Policy Formulation and Analysis	381	191	572
2. A2. Strategic and Operational Planning	199	386	585
3. A3. Policy and Donor Coordination	80	0	80
4. A4. Public Relations and Communication	131	93	225
Subtotal A. Strengthening Policy, Planning and Donor Coordination	791	671	1,462
B. B. Implementing Organizational & Financing Reforms			
1. B1. Strengthening PHC Mgt and Fin	765	1,134	1,899
2. B2. Hospital Mgt and BPMCS	778	1,314	2,093
3. B3. MOH Capacity Building	87	213	300
Subtotal B. Implementing Organizational & Financing Reforms	1,630	2,662	4,291
C. C. Primary Health Care in Selected Rayons			
1. C1. PHC Infrastructure	4,811	2,270	7,081
2. C2. PHC Services and Outreach	65	0	65
3. C3. PHC Training	737	174	911
Subtotal C. Primary Health Care in Selected Rayons	5,613	2,443	8,056
D. D. Project Management			
1. D1. Project Mgt	537	79	616
Subtotal D. Project Management	537	79	616
E. Project Preparation Facility	300	0	300
Total BASELINE COSTS	8,871	5,855	14,726
Physical Contingencies	650	389	1,040
Price Contingencies	50	185	235
Total PROJECT COSTS	9,570	6,430	16,000

Tajikistan
Community and Basic Health Project
Expenditure Accounts Project Cost Summary

	(US$) ('000's)		
	Local	Foreign	Total
I. Investment Costs			
A. Civil Works	3,787	35	3,821
B. Goods	1,152	4,083	5,235
C. Technical Assistance Disbursement Account			
International TA	524	1,346	1,870
Local TA	1,739	0	1,739
Subtotal Technical Assistance Disbursement Account	2,263	1,346	3,609
D. Training Disbursement Account			
External Training	48	390	438
Local Training	1,054	0	1,054
Subtotal Training Disbursement Account	1,102	390	1,492
G. PPF	300	0	300
Total Investment Costs	8,603	5,854	14,457
II. Recurrent Costs			
B. Equipment O&M	34	1	36
C. Other Operating Expenditures	234	0	234
Total Recurrent Costs	268	1	269
Total BASELINE COSTS	8,871	5,855	14,726
Physical Contingencies	650	389	1,040
Price Contingencies	50	185	235
Total PROJECT COSTS	9,570	6,430	16,000

Annex 6: Implementation Arrangements

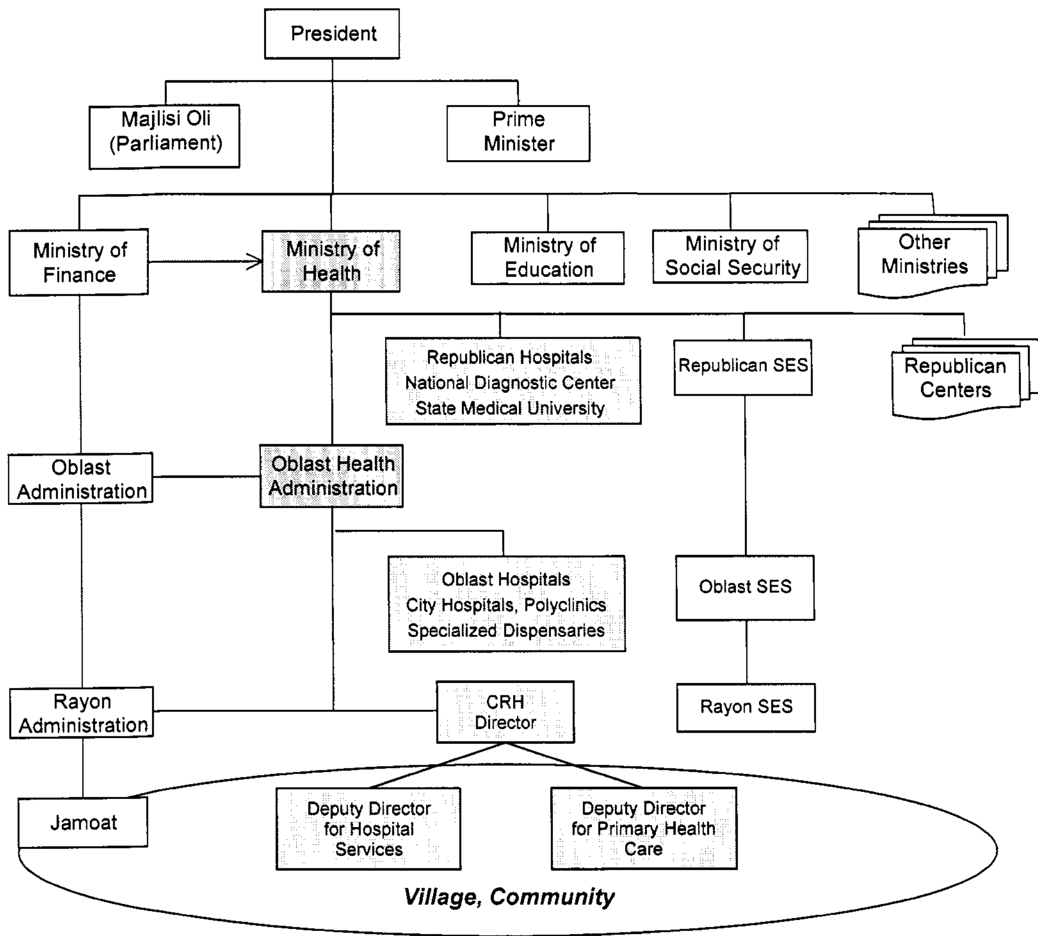
TAJIKISTAN: COMMUNITY AND BASIC HEALTH PROJECT

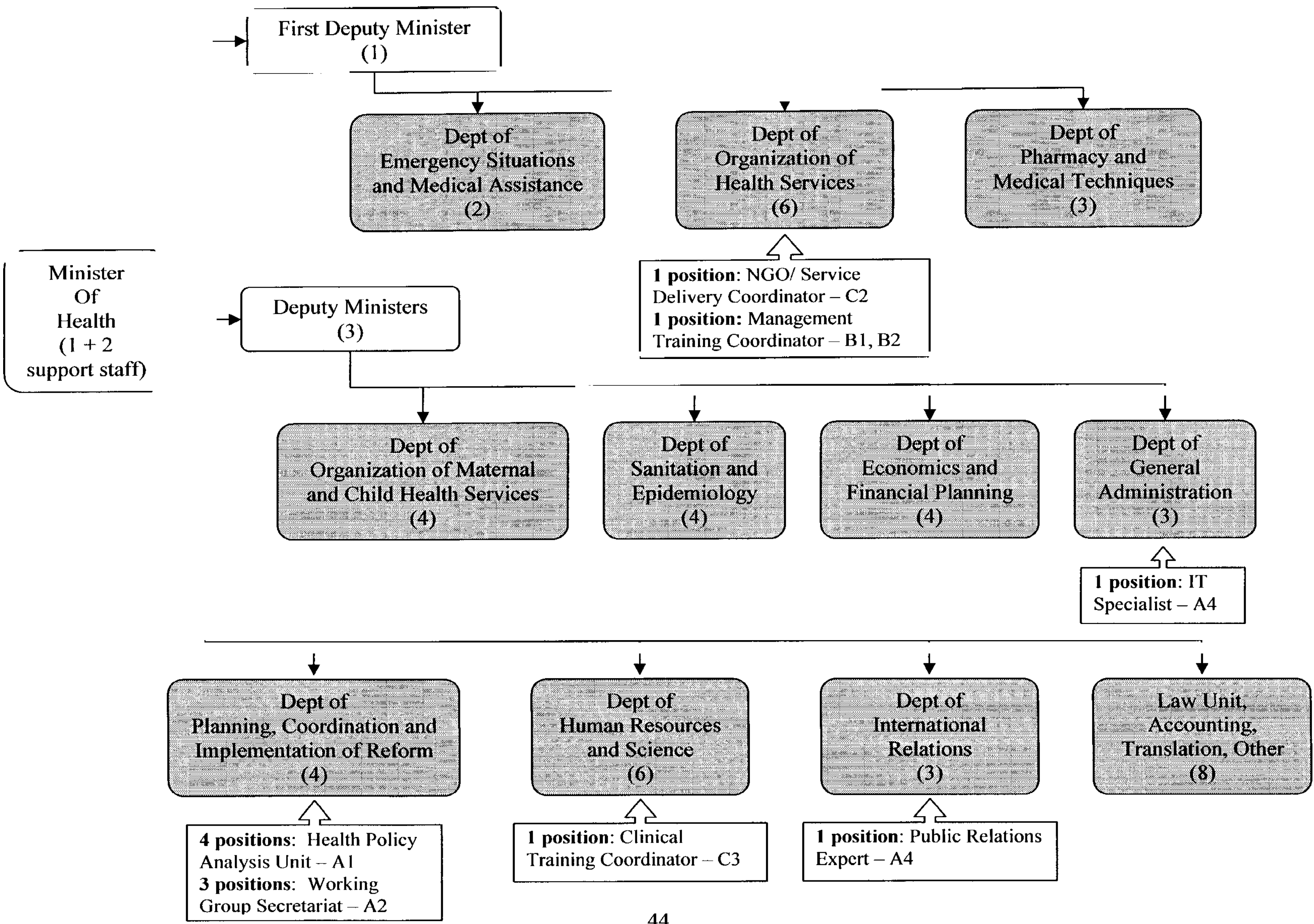
Management of the Project will be carried out by a Project Implementation Unit (PIU). The unit will initially be off-site from the MOH, due to space constraints, but over the course of the Project, it is hoped it will be fully integrated into the Ministry. This unit will be responsible for budgeting, procurement, financial management, monitoring and evaluation, and other non-technical functions of the project. The unit will consist of a Director, Deputy Director, Financial Management Specialist, Procurement Specialist, Procurement Assistant, Chief Accountant, Cashier, Legal Advisor, Office Manager and Assistant, Translator, drivers and other auxiliary staff. In addition to these administrative functions, the PIU will also be responsible for supervising all major civil works of the project under Component C1. For this activity, the PIU will employ two technical advisors and one account estimator, as well as field supervisors, as needed.

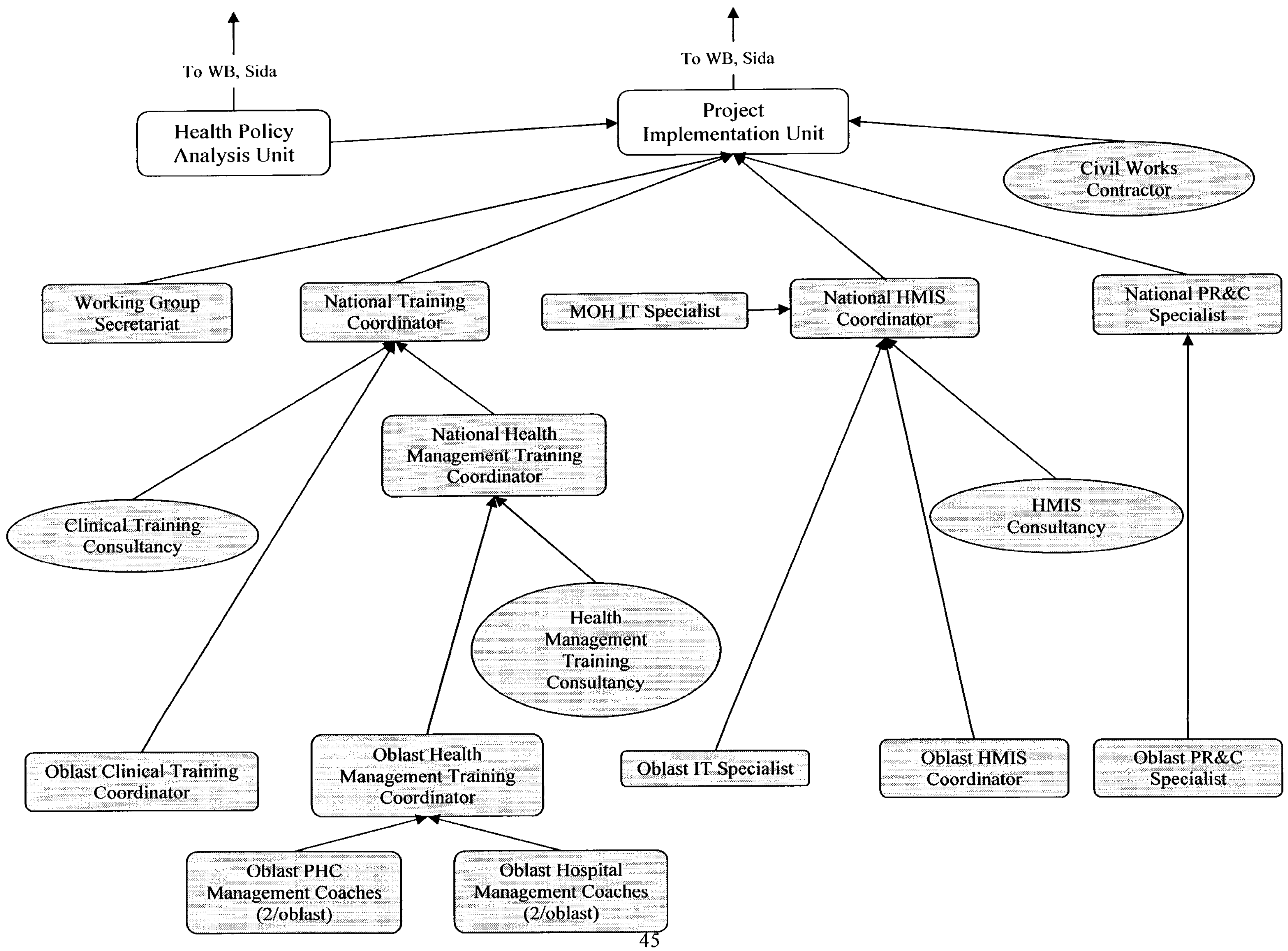
With the exception of the above, technical management of project activities will reside within the MOH. (See chart below.) The project will fund a number of local consultant positions inside the Ministry to support critical project objectives. These positions include the following: four positions which will comprise the Health Policy Analysis Unit (A1; note that one of these is an international consultancy to be funded by Sida); three positions which will comprise the new Working Group Secretariat (A2, A3), one Public Relations Expert to support the Department of International Relations (A4), one Information Technologist (IT) to support the Ministry (A4), and three Project Component Coordinators for Clinical Training (C3), PHC Service Delivery (C2), and Management Training (B1, B2). These positions will operate within, and report to, appropriate officials in the Ministry. Their activities, especially those of the Coordinators, will also be linked to activities being carried out by the PIU, such that the PIU can properly monitor and support the overall objectives of the Project.

Implementation of civil works activities will be based on a division of activities between some managed in-house and others which would be commercially procured. PIU staff will manage all aspects of component implementation; responsibilities will comprise, *inter alia*, planning and sequencing of activities, procurement of works, goods and services, and overall supervision and monitoring of quality and progress on site. PIU staff at central level will be responsible for overall component management and coordination and staff posted in the field will be responsible for technical monitoring and supervision. Staff complements and logistical support at central and field levels will be strengthened to handle the anticipated workloads. Design of facilities, construction work, supply of furniture and medical equipment, and technical supervision will be contracted out to national or international, reputed contractors and suppliers. To ensure high technical standards of all works, goods and services, required for the subcomponent to attain quality outputs, all procurements would be competitive, either national or international, with screening and short-listing of potential suppliers prior to the tenders.

Organizational Structure of the Government Health System in Tajikistan




Organizational Structure of the Ministry of Health
Existing Staff and Project-Proposed Long-Term Consultants Integrated into MOH
(Total Staff June 2005: 54)
Minister Of Health (1 + 2 support staff)
First Deputy Minister (1)
Dept of Emergency Situations and Medical Assistance (2)
Dept of Organization of Health Services (6)
Dept of Pharmacy and Medical Techniques (3)
1 position: NGO/ Service Delivery Coordinator – C2
1 position: Management Training Coordinator – B1, B2
Deputy Ministers (3)
Dept of Organization of Maternal and Child Health Services (4)
Dept of Sanitation and Epidemiology (4)
Dept of Economics and Financial Planning (4)
Dept of General Administration (3)
1 position: IT Specialist – A4
Dept of Planning, Coordination and Implementation of Reform (4)
Dept of Human Resources and Science (6)
Dept of International Relations (3)
Law Unit, Accounting, Translation, Other (8)
4 positions: Health Policy Analysis Unit – A1
3 positions: Working Group Secretariat – A2
1 position: Clinical Training Coordinator – C3
1 position: Public Relations Expert – A4


Biannual Reporting Arrangements
for Project Monitoring and Evaluation
To WB, Sida
To WB, Sida
Health Policy Analysis Unit
Project Implementation Unit
Civil Works Contractor
Working Group Secretariat
National Training Coordinator
MOH IT Specialist
National HMIS Coordinator
National PR&C Specialist
National Health Management Training Coordinator
Clinical Training Consultancy
HMIS Consultancy
Health Management Training Consultancy
Oblast Clinical Training Coordinator
Oblast Health Management Training Coordinator
Oblast IT Specialist
Oblast HMIS Coordinator
Oblast PR&C Specialist
Oblast PHC Management Coaches (2/oblast)
Oblast Hospital Management Coaches (2/oblast)

Annex 7: Financial Management and Disbursement Arrangements

TAJIKISTAN: COMMUNITY AND BASIC HEALTH PROJECT

Financial management arrangements of the PIU under the MOH were assessed in June 2005 to determine the status of readiness for the proposed project. These financial management arrangements include systems of budgeting, accounting, financial reporting, auditing, and internal controls. The PIU has established and maintained a computerized accounting system, using appropriate accounting software that meets the requirements of the World Bank and Government financial reporting requirements. The assessment that supplemented the financial management supervision carried out in January 2004, concluded that the financial management arrangements established by the PIU meet requirements of the World Bank. However, the PIU financial manager has recently resigned and has been replaced by someone with little experience with Bank procedures and requirements. The manual of financial procedures developed under the PHC project will need to be revised to reflect accounting and financial reporting requirements of the proposed project. The accounting software will also need to be adapted to generate FMRs required under the proposed project. These actions should be implemented by December 22, 2005.

Country Financial Management Issues. A Country Financial Accountability Assessment (CFAA) for Tajikistan was completed in 2003 and was disseminated to Government authorities in October 2003. The CFAA concluded that the country's fiduciary environment is extremely weak and the risk to public funds is high. The findings show, among other things, that systems of public accountability function poorly and public sector transparency is still a problem at all levels of government. Most project implementing entities use the cash basis of accounting, which is not in accordance with IAS/IFRS, but which in many cases is sufficient for proper accounting of project resources and expenditures. Internal audit is not a common practice; and external audit is practiced by individuals and a small number of audit firms. Audits required by IDA have been performed by audit firms pre-qualified by the Bank to audit Bank-financed projects. Currently the Bank does not place any reliance on audits conducted by the State Financial Control Committee (SFCC), and for the past two years audit of the IDA portfolio has been conducted by a firm based in Bishkek, Kyrgyz Republic, under the Block Audit Contract arranged by the Aid Coordination Unit (ACU). To minimize financial risks associated with low capacity and public accountability issues, there has been the need to "ring fence" financial resources in Bank projects in order to provide the appropriate fiduciary safeguards.

Implementation Arrangements. On a day to day basis, project activities will be implemented by the PIU under the Ministry of Health, consisting of dedicated, full time staff under the leadership of the Project Director. The staff will include specialists in procurement, financial Management, and administrative staff. The PIU will be responsible for developing and updating the consolidated Project Implementation Plan, ensuring that project activities are implemented according to the legal documents, procurement plan and Project Operations manual, reporting on project progress to the Government, the World Bank and Sida, ensuring that procurement of goods and services is done in a timely manner and in accordance with World Bank guidelines, managing project funds, maintaining accounts, including the Special Accounts, getting the accounts audited, ensuring adequate budget provisions for the project in the national budget, facilitating the work of consultants, and reviewing consultant outputs.

Strengths and Weaknesses. The PIU has successfully implemented the closed Primary Health Project, and is currently implementing the PPF and PHRD which are financing preparation of the proposed project. Staffs have gained significant experience with financial management, procurement and disbursement procedures of the World Bank. The PIU has established a financial management system that is capable of monitoring resources and expenditures of the project and generate reports such as the FMR. However, the PIU financial manager, who has satisfactorily managed the financial management functions of the PIU

has since left, and has been replaced by a person who has little experience with Bank procedures and requirements, and who will, therefore, require some training. He is expected to participate in the establishment of a financial management system capable of recording all transactions and balances, and support the preparation of FMRs. The manual of financial procedures prepared for the closed project will need to be revised to reflect the financial management requirements of the new project. The accounting software will also require some adaptation in order to be able to generate FMRs.

Staffing of the Accounting/Finance Function. The PIU finance unit will include a financial manager and an accountant /disbursement specialist. The financial manager will be responsible for all aspects of financial management and accounting, including managing the special account. S(h)e will be assisted by a disbursement specialist for disbursement functions, and project accounting - maintaining books of accounts, reporting day-to-day transactions and preparing accounting reports and financial statements, as well as monitoring financial flows to the project. The financial manager will be involved in budget preparation for the project and have primary responsibility for the quarterly FMR, and prepare annual financial statements for audit. The financial manager will also manage an effective system of internal controls, ensuring adherence to established financial procedures, and safeguarding the resources and assets of the project.

Accounting and Internal Control Systems. The PIU FMS staffs have gained experience with Bank procedures during implementation of the Primary Health Care Project, and have established key internal control mechanisms in the application and use of funds. The financial procedures manual, used during implementation of PHCP, will be updated to suit the requirements of the proposed project, to reflect the PIU structure as well as the flow of funds to support project activities. Accounts and records for the project will be maintained during implementation by the PIU, that will operate and maintain a financial management system (FMS) capable of generating Financial Monitoring Reports (FMRs) in accordance with formats agreed with the World Bank. Books of accounts for the project will be maintained by the PIU based on generally accepted accounting standards. The financial manager will be responsible for overall project financial management, ensuring proper maintenance of books and accounts for the project, preparation and dissemination of financial statements and FMR, and timely audits of the project.

Financial Monitoring and Reporting. Quarterly FMRs, including Financial Statements, Physical Progress Reports and Procurement Reports, in formats acceptable to the World Bank, will be generated from the financial management system within 45 days of the end of each quarter. The first quarterly FMR will be submitted after the end of the first full quarter after disbursements commence. Formats of the annual financial statements and the FMR will be incorporated in the revised financial procedures manual. The FMRs include: (a) Project Sources and Uses of Funds, (b) Uses of Funds by Project Activity, (c) Output Monitoring Reports, (in Tables and Narrative form), and (d) Procurement Reports. The project accounting software will be adapted to generate FMRs, incorporating all components, categories and performance indicators which are acceptable to the World Bank. Sample reports were agreed with the Bank during negotiations and will be annexed to the minutes of negotiations.

Information Systems. The "1C" Accounting Software, a Russian accounting program commonly used by World Bank funded projects in Tajikistan, has been installed in the PIU. The software includes, inter alia, a customizable chart of accounts, foreign and local currency, English and Russian language, and Excel and Word exporting, etc. The software will need to be customized to respond to the Project components and categories under the new project, and will be able to produce routine reports required for project monitoring and management, and annual reports required by the World Bank and other donors. The system will generate quarterly Financial Monitoring Reports in accordance with formats agreed with the Bank.

Planning and Budgeting. The PIU will prepare annual budgets in line with the Procurement Plans and these budgets will form the basis for spending and project resources. These budgets, prepared in accordance with the FMR format (disbursement categories, components and activities, financial sources, account codes, and by quarter), will establish physical targets to ensure linkages between expenditures and physical progress, and proper comparison between actual and budgeted performance. Review of actual results against the budget will be a key managerial tool for monitoring financial performance of the project. The financial procedures manual will prescribe the appropriate manner for preparing budgets to satisfy the government and World Bank requirements. A detailed budget for the first full year of project implementation, broken down by quarter, will be prepared before the grant becomes effective.

Audit Arrangements. There will be annual external audits of the project financial statements, covering all aspects of the project, including all funds irrespective of source. The audits will be performed by independent private sector auditors acceptable to the World Bank, and in accordance with International Standards on Auditing (ISA), and the World Bank's guidelines on auditing as stated in the guidelines: *Annual Financial Reporting and Auditing for World Bank-financed Activities* (June 2003), and other guidance that might be provided by the World Bank from time to time. The auditors' terms of reference (TORs) will be prepared by the PIU and cleared by the Bank before the engagement of the auditor. They will include both the audit of financial transactions and an assessment of the operation of the FMS, including a review of the internal control mechanisms. The annual audit reports will be in a format in accordance with ISA and World Bank guidelines, and they will include a single opinion on the financial statements of the project, incorporating the project financial statements, including Special Account Reconciliation, and SOE Withdrawal Schedule; as well as a Management Letter. The audit reports will be submitted to the Bank not later than six months after the end of the fiscal year to which they relate. The PIU will provide the auditor with full access to project-related documents and records and with the information required for the purpose of the audit. Sample TORs for project audit will be included in the financial procedures manual.

Disbursement/Flow of Funds Arrangements. The proceeds of the IDA Grant will be disbursed over a period of four years, or for such longer period as will be agreed with IDA. Grant funds will initially flow to the project via disbursements to the Special Account (SA) opened by the Recipient under terms and conditions acceptable to the Bank. Disbursements will follow transaction-based method, i.e., the traditional Bank procedures (reimbursements with full documentation, Statements of Expenditure (SOEs), direct payments and special commitments), as report-based (disbursements based on quarterly FMR) is not considered feasible in the Tajikistan portfolio. During implementation, withdrawals from the Grant Account will be requested in accordance with the guidance provided in the Disbursement Letter. Withdrawal applications may be signed by the Ministry of Finance or an authorized representative or designate, with written delegated authority. The financial manager will ensure completeness and accuracy of all withdrawal applications and will append her/his signature as part of the internal control procedure.

Special Account. The PIU will manage the Special Account, including preparing withdrawal applications and supporting documentation, replenishment and timely reconciliation of the Special Account. The replenishment applications should be submitted at least every month and must include the Special Account Reconciliation Statement and relevant supporting documentation. Detailed instructions for withdrawal of funds from the Grant Account will be communicated in a Disbursement Letter upon approval of the grant. The Special Accounts will be opened in a commercial bank acceptable to the World Bank. A local currency project account may also be opened by the PIU to facilitate payment for local project expenditures.

Use of Statements of Expenditure (SOEs). Disbursement arrangements under the Project may be carried out using SOE procedures for: (i) works contracts less than US$100,000 equivalent each (ii) goods contracts costing less than US$100,000 equivalent each; (iii) consulting services contracts with firms

costing less than US$100,000 equivalent each; (iv) consulting services contracts with individual consultants costing less than US$20,000 each; (v) training; and (vi); incremental operating costs, under such terms and conditions as the Association shall specify by notice to the Recipient. The required supporting documentation and other records will be retained by the PIU for at least one year after the receipt by IDA of the audit report for the year in which the last disbursement was made. The documentation will be made available for review by the independent auditors and by the visiting IDA staff upon request.

Financial Management Action Plan. Although financial management arrangements of the PIU are generally adequate there are a few actions required to ensure that they are fully satisfactory. The action plan below was discussed with Recipient during negotiations. Successful implementation of the action plan will ensure establishment of financial management system that meets requirements of the Bank.

	Action	Responsibility	Due Date	Remarks
1	***FM Procedures Manual.*** Revise existing manual to fully documenting the following procedures: budgeting, accounting and internal control, including description of the accounting system and books of accounts, disbursement and flow of funds (including chart), financial reporting, including FMR, annual reports and audit.	PIU	Revised Manual should be ready before December 22, 2005	A manual already exists and will require only minor updates to reflect the characteristics of the project.
2	***Project Accounting and Financial Reporting System.*** Upgrade existing accounting software, to reflect requirements of the new project, including capacity to generate FMR without manual summarization in excel; and provide appropriate training to the relevant staff on application and maintenance of the system. Test the accounting and reporting system by producing sample FMR, based on PHRD grant, for submission to the Bank for review and comments.	PIU	By December 22, 2005	Sample reports to be based on activities under the PHRD grant, will be reviewed by the Bank prior to Board Date, i.e. December 21, 2005. Format and content to be agreed during negotiations.
3	***Staffing of the FM Unit.*** To consist of a Financial Manager, Disbursement Specialist/project Accountant.	PIU	FMS has been hired; others during implementation.	TOR for all staff to be cleared by the Bank.

Financial Management Supervision Plan. The Bank will conduct risk-based financial management supervision, at appropriate intervals, to monitor progress of project implementation. The financial management supervision will pay particular attention to: (i) project accounting and internal control systems; (ii) budgeting and financial planning arrangements; (ii) review of project's financial monitoring reports; (iii) review of audit reports, including financial statements and remedial actions recommended in the auditor's Management Letters; (v) review of implementation of progress; and (iv) disbursement management and financial flows, including counterpart funds, etc.

Value Added Tax. In accordance with the current Tax Code, any VAT paid out of the proceeds of donor funded projects is subject to reimbursement by the Government. It was agreed at Negotiations that while Grant funds will be used to pay for 100% of project expenditures, inclusive of VAT, appropriate

procedures will be put in place and described in the Project Operational Manual for proper accountability of VAT refunds. Such refunds would be retained in a separate local currency account and be available for project related activities in accordance with expenditure plans agreed with the Bank. It was noted that these procedures would cease to be necessary should the Government provide an exemption from VAT for Projects financed by the Bank, as is expected in January 2006.

Proceeds of the Grant

The table below sets forth the Categories of items to be financed out of the proceeds of the Grant, the allocation of the amounts of the Grant to each Category and the percentage of expenditures for items so to be financed in each Category:

Category	Amount of the Grant Allocated (Expressed in SDR Equivalent)	% of Expenditures to be Financed
(1) Works, goods, consultants' services, including training and audit	5,960,000	100%
(2) Operating costs	210,000	100%
(3) Refunding of Project Preparation Advance	210,000	Amount due pursuant to Section 2.02(c) of this Agreement
(4) Unallocated	520,000	
TOTAL	6,900,000	

Annex 8: Procurement Arrangements

TAJIKISTAN: COMMUNITY AND BASIC HEALTH PROJECT

A. General

Procurement for the proposed project would be carried out in accordance with the World Bank's "Guidelines: Procurement under IBRD Loans and IDA Credits" dated May 2004; and "Guidelines: Selection and Employment of Consultants by World Bank Borrowers" dated May 2004, and the provisions stipulated in the Grant Agreement. The various items under different expenditure categories are described in general below. For each contract to be financed by the Grant, the different procurement methods or consultant selection methods, the need for pre-qualification, estimated costs, prior review requirements, and time frame are agreed between the Recipient and the Bank in the Procurement Plan. The Procurement Plan will be updated at least annually or as required to reflect the actual project implementation needs and improvements in institutional capacity.

Procurement of Works. Works procured under this project would include: rehabilitation or replacement of Primary Health Care (PHC) facilities in 2-4 rayons in Sughd and Khatlon oblasts.

Procurement of Goods. Goods procured under this project would include: Furniture and computers for 41 rayons, a management information system for utilization tracking and basic disease surveillance, and outreach vehicles for rayon units. For procurement of goods and works under the project, the following methods will be used: ICB, NCB for Works, Shopping and Direct Contracting. The Bank's Standard Bidding Documents (SBD) for all ICB contracts will be used. Basic medical equipment and supplies may be procured from the United Nations Children's Fund (UNICEF) in accordance with the provisions of paragraph 3.9 of the Guidelines.

Selection of Consultants. Consulting services from firms and individuals will be required for, among others, Policy Formulation and Analysis, Strategic and Operational Planning, Public Relations and Communication, Strengthening Primary Health Care (PHC) Management and Finance, Hospital Management, MOH Capacity Building, PHC Training, Project Management, Financial Management System, Audit Services. The following methods will be used for selecting firms and individuals whose services will be required for the project: Quality and Cost Based Selection (QCBS); Least Cost Selection for Project Audit (LCS); Selection Based on Consultants' Qualifications (CQ), Individual Consultants (IC), and, where justified, Single Source Selection (SSS). Shortlist of consulting firms for services estimated to cost less than US$100,000 equivalent per contract may be composed entirely of national consultants in accordance with the provisions of paragraph 2.7.

Training. Training will include Project related study tours, training courses, seminars, workshops and other training activities not included under goods or service providers' contracts, including costs of training materials, space and equipment rental, travel and per diem costs of trainees and trainers.

Operating Costs. Operating costs will include equipment operation and maintenance, including vehicles, communications, such as email, telephone and fax, utilities, and office space rental costs. Operating costs will be incurred according to an annual budget satisfactory to the Bank and using procedures to be described in the Project Operational Manual.

B. Assessment of the agency's capacity to implement procurement

An assessment of the capacity of the MOH to implement procurement actions for the project has been carried out by Mr. Fasliddin Rakhimov on October 16, 2005. The assessment reviewed the organizational

structure for implementing the project and the interaction between the project's staff responsible for procurement and the MOH's relevant central unit for administration and finance.

The MOH will have overall responsibility for implementing this project. Initially, the MOH will use the services of its Project Implementation Unit (PIU) for this purpose, but over time, with the support of the capacity building component of the project, the functions of the PIU will be integrated within the MOH's appropriate departments. The PIU will consist of a Director, Deputy Director, Financial Management Specialist, Procurement Specialist, Procurement Assistant, Chief Accountant, Cashier, Legal Advisor, Office Manager and Assistant, Translator, drivers and other auxiliary staff. The PIU has engaged the services of the former procurement officer of the Health I project. He has more than three years of experience in conducting international procurement in accordance with the Bank procurement guidelines.

C. Procurement Considerations

The Country Procurement Assessment Review (CPAR) and the experience of other IDA- and IFI-funded projects indicate that the procurement activities under the proposed project are expected to face the following challenges:

(i) Government officials, who would be involved in project procurement through Tender Committees, may not be familiar with procurement procedures.
(ii) The bureaucratic system creates opportunities for informal interference in procurement process by senior officials.
(iii) Suppliers and contractors, and goods and works required for the project in the current country conditions, especially in remote region may not be available. As a result, there may be inadequate competition resulting in higher prices of goods, works and services that would be required for achieving project objectives.
(iv) MOH may not have the necessary organization or staff for conducting its procurement in accordance with the revised procurement law which, if passed by Parliament, would decentralize public procurement to ministries; this may not help achieve the objective of progressively integrating the PIU procurement functions with MOH.

The following strategy has been devised to mitigate the above-mentioned risks to project implementation:

- A half-day seminar would be organized for high officials of the government agencies, central and local, involved in project implementation.
- A one day project launch workshop should include not only the MOH staff involved in project implementation, including the PIU staff, but also the representatives of local government agencies who will be involved in project implementation.
- For all procurement, the POM, to be adopted by effectiveness, would include procurement methods to be used in the project along with their step by step explanation as well as the standard and sample documents to be used for each method.
- The PIU would create a data base of suppliers of the required goods, construction contractors and consultants (firms and individuals, as well as an inventory of the available goods in the remote regions). The data base would also include information on current prices of goods. For this purpose, the PIU would use all available internet resources, including the UN websites.
- As soon as the revised procurement law is passed by Parliament, the MOH would assign the procurement function to one of its departments, such as the finance/administration department, and equip this department with procurement staff and equipment with the support of the project. This will enable the PIU procurement staff to train their MOH and other counterparts in procurement so that they can eventually take over this function from the PIU. For this purpose, the procurement officer of

the PIU and a number of other MOH officials would be trained as trainers under the project. These trainers then should train the MOH staff and the staff of other health-related agencies in procurement.

D. Procurement Plan

The Recipient, at appraisal, developed a procurement plan (PP) for project implementation which provides the basis for the procurement methods to be used during project implementation. This plan has been agreed between the Recipient and the Bank Project Team. The plan will be available in the project's database and on the Bank's external website. The Procurement Plan will be updated in agreement with the Project Team annually or as required to reflect the actual project implementation needs and improvements in institutional capacity. The procurement plan shall indicate the contracts subject to Bank's prior review.

E. Frequency of Procurement Supervision

In addition to the prior review supervision to be carried out from Bank offices, the capacity assessment of the Implementing Agency has recommended one supervision mission per year to visit the field to carry out post review of procurement actions.

F. Details of the Procurement Arrangements Involving International Competition

1. Goods, Works, and Non Consulting Services

1	2	3	4	5	6	7
Ref. No.	Contract (Description)	Procurement Method	P-Q	Domestic Preference (yes/no)	Review by Bank (Prior / Post)	Expected Start Date
1	Office Equipment*	ICB	No	Yes	Prior	March 2006
2	Furniture**	ICB	No	Yes	Prior	March 2006
3	Radio –Communication Equipment	ICB	No	Yes	Prior	August 2008
4	Vehicles	ICB	No	Yes	Prior	June 2006
5	Sanitary vehicles	ICB	No	Yes	Prior	May 2007
6	Medical equipment	ICB	No	Yes	Prior	February 2008
7	Diesel generators	ICB	No	Yes	Prior	November 2008
8	Medical literature	DC	No	n/a	Prior	February 2006
9	Procurement of ICD-10 (International Codes of Diseases)	DC	No	n/a	Prior	April 2006

* Office equipment for 41 rayons and 2 oblast centers, 41 CRH and health departments and Health facilities in pilot rayons.

** Office furniture for 41 rayons and 2 oblast health centers, for 41 CRH and 2 oblast departments and health facilities in pilot rayons.

2. Consulting Services

1	2	3	4	5
Ref. No.	Description of Assignment	Selection Method	Review by Bank (Prior / Post)	Expected Start Date
1	Development of project design and supervision	QCBS	Prior	March 2006
2	Development of Sector Strategy	QCBS	Prior	April 2006
3	Development of Public Relations	CQS	Prior	May 2006
4	Strengthening Hospital Mgmt & Implementing the BPMCS	QCBS	Prior	May 2006
5	HMIS Development	QCBS	Prior	April 2006
6	Consultants on reforms in Sogd and Khatlon oblast	SSS	Prior	January 2006
7	Family Medicine Training	QCBS	Prior	February 2006
8	Financial Management System	QCBS		
9	Audit Services	LCS	Prior	February 2006
10	MOH Coordinator for HMIS	SSS	Prior	January 2006
11	Household Survey	CQS	Prior	January 2009

G. Prior Review Threshold

The project procurement plan will indicate which contracts will be subjected to prior or ex-post review. For this purpose, the following thresholds will be used:

a. All contracts awarded through ICB (estimated to cost more than US$100,000).
b. First NCB contract for works.
c. All TORs for consulting services, irrespective of the contract value.
d. Contracts with consulting firms (US$100,000) and contracts with individual consultants estimated to cost US$20,000 or more each.
e. Single source or direct contracting is also subject to justification.

The above thresholds can be subject to revision as the project implementation progresses and the implementation agency has acquired higher procurement capacity.

Annex 9: Economic and Financial Analysis

TAJIKISTAN: COMMUNITY AND BASIC HEALTH PROJECT

Economic justification

The Project would improve the equity and reliability of resource flows to PHC and would thus strengthen the delivery of cost-effective primary health services including maternal and child health services, preventive services such as immunization and first-level curative care. The quality and efficiency of PHC would also be improved by supporting the development of a professional cadre of PHC managers and by efforts to broaden the focus of PHC to include community outreach and health promotion work: the latter being among the most cost-effective of health interventions and an area where PHC in Tajikistan is especially weak. The Project would improve equity by ensuring that public funds are targeted to PHC and to vulnerable groups—children under five, pregnant women and other social beneficiaries to be covered under the BPMCS—and would improve transparency and predictability in out-of-pocket health spending by introducing a transparent fee structure and payment methods for hospital services not covered by the BPMCS. The magnitude of these benefits is difficult to quantify at a stage in the reform process where the emphasis is still on broad structural reforms. More relevant at this stage is to test the fiscal sustainability of Project-supported interventions, especially those with recurrent cost implications such as reconstruction of health facilities or introduction of health information systems.

Fiscal sustainability

Table 3 lists Project investments by component. Only investments with a recurrent cost impact are included; component C2, which would involve large NGO contracts to improve service delivery in PHC, is a special case and is considered separately. Recurrent costs were estimated with the following criteria: maintenance allowances of 2.5 percent of investment cost for civil works [assuming the same quality as under the Primary Health Care Project], 5 percent for IT and medical equipment and 10 percent for vehicles; overall inflation of 14 percent cf. CPI inflation of 5 percent, given the unpredictability of inflation rates for civil works and equipment; and depreciation to zero of 5 years for IT equipment, 10 years for vehicles and medical equipment and 50 years for civil works. Even including component A, for which the Kyrgyz experience suggests that donor funding is likely to be available beyond the current project, the total recurrent cost impact of the Project is estimated at <u>USD ~1.1 million per annum</u>.

Table 3: Recurrent Cost Impact of Project Investments

Component	Cost ($)	Maintenance Factor (Y)	$/Y	Depreciation Factor (D)	Annual recurrent exp.
A1	$50,000	1	$50,000		$50,000
A3	$20,000	1	$20,000		$20,000
B1 IT	$500,000	20	$25,000	5	$125,000
B1 VEH	$250,000	10	$25,000	10	$50,000
B1 TA	$25,000	1	$25,000		$25,000
B2 IT	$500,000	20	$25,000	5	$125,000
C1 CW	$7,000,000	40	$175,000	50	$315,000
C1 EQ	$2,500,000	20	$125,000	10	$375,000
			$470,000		**$1,085,000**

* Y and D in years

The government faces two options in covering these additional costs from domestic sources. It can either finance them by increasing the health budget—as it plans to do—or it can reallocate efficiency gains to

cover increased recurrent expenditure. We examine both options. Table 4 illustrates actual and projected increases in total government health expenditure from 2004 to 2007. To meet these projections, GOT would have to increase government health spending by USD ~7-9 million in CY2006. It is not clear whether this target will be met. However GOT has made a commitment—supported by PBC—to increase PHC spending by at least 40 percent in CY2006, following similar increases in each of the past two years. With a total PHC budget of USD 5 million in CY2005, this translates to an increase of USD 2 million. Assuming this increase is split 40:60 between PHC salaries and non-salary recurrent expenditures, the latter would increase by USD 1.4 million: i.e. fractionally more than the amount required to cover additional expenditures engendered by the Project. Because these additional expenditures were estimated conservatively, e.g. assuming an immediate need for full maintenance on new facilities and including a higher-than-expected allowance for inflation, the Project's investments are considered sustainable within a reasonable margin of error.

Table 4: Actual and Projected Government Health Spending, 2004-2007

Year	2004	2005	2006	2007
Public health spending/GDP	1.1	1.3	1.5	1.7
GDP (billion $)	2.3	2.5	2.7	2.8
Projected health spending (million $)		**32.3**	**39.9**	**47.6**
Actual health spending (million $)		30.1		

Efficiency gains

Hospitals in Tajikistan are operating at well below their optimum efficiency. Bed occupancy rates are estimated at between 28 and 50 percent, the average length of stay (ALOS) is around 13.5 days, and the current input-based financing system provides no incentives for these figures to change. The introduction of case-based payments is designed to address these issues by creating incentives for hospitals to match costs to the actual volume of services delivered. The other alternative—planned rationalization *without* changes in the incentives regime—is politically complex and seldom succeeds because of the influence of vested interests and their resistance to government-led decisions to rationalize facilities or downsize hospitals. Experience with PHC rationalization in the Primary Health Care Project illustrates this phenomenon; and for this reason, the approach being taken now—led by the government and its decision to establish a Basic Benefit Package—is to stimulate rationalization in the first place through payment system reform, and to follow this with planned rationalization in 4-5 years, once initial efficiency gains have been obtained and several years' data on hospital utilization has been accumulated by the new hospital information and payment system. Estimating the efficiency gains from this approach is not straightforward. Kyrgyzstan introduced similar reforms in the late 1997. In the two years between 1997 and 1999, Kyrgyzstan's ALOS fell from 14.3 to 11.6: a decline, in relative terms, of 9.5 percent per year. There is vast room for rationalization in Tajikistan's hospitals, as the BOR of 28 suggests. Estimating efficiency gains based on the Kyrgyz experience and with highly conservative assumptions—i.e. assuming efficiency gains relative only to the status quo, excluding salaries and capital spending and applying the gains only to non-salary recurrent expenditures, and assuming no aggregate change in demand—there is scope to obtain gains of between USD 1.1 and 1.8 million over the next four years. This translates to savings of 3-6 percent in government health spending that could be used to finance the provision of hospital services for groups exempt from co-payments under the BPMCS.

Annex 10: Safeguard Policy Issues

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This project is Category C. The project is expected to mainly finance rehabilitation of small primary health care facilities. It is, however, conceivable that facilities might need to be replaced within the existing building footprint, either by *de novo* construction or by installation of prefabricated units. These are expected to pose minimal environmental risks; and the Recipient, though not required to, has prepared an Environmental Management Plan for this contingency and will activate the provisions of this Plan should the Project call for more than rehabilitation and/or installation of prefabricated units. The Recipient's capacity to implement these measures is considered adequate, should such implementation become necessary.

Annex 11: Project Preparation and Supervision

TAJIKISTAN: COMMUNITY AND BASIC HEALTH PROJECT

	Planned	Actual
PCN review	02/07/2005	02/07/2005
Initial PID to PIC		02/14/2005
Initial ISDS to PIC		03/10/2005
Appraisal		06/06/2005
Negotiations	11/14/2005	11/14/2005
Board/RVP approval	12/22/2005	
Planned date of effectiveness	02/06/2006	
Planned date of mid-term review	05/01/2008	
Planned closing date	02/08/2010	

Key institutions responsible for preparation of the project:
Ministry of Health

Bank staff and consultants who worked on the project included:

Name	Title	Unit
Peyvand Khaleghian	Health Specialist, TTL from 9/04	ECSHD
Ross Pavis	Operations Officer	ECSHD
Akiko Maeda	Lead Health Specialist/TTL to 9/04	MNSHD
Sarbani Chakraborty	Senior Health Specialist	ECSHD
Saodat Bazarova	Operations Analyst	ECSHD
Arsen Khadziev	Operations Analyst	ECSHD
Naushad A. Khan	Lead Procurement Specialist	ECSPS
John O. Ogallo	Financial Management Specialist	ECSPS
Andrew Mackie	Financial Management Specialist	ECSPS
Nikolai Soubbotin	Senior Counsel	LEGEC
Hannah Koilpillai	Finance Officer	LOAG1
Fasliddin Rakhimov	Procurement Analyst	ECSPS
Anne Gillette	Summer Intern	ECSHD
Julie Wagshal	Program Assistant	ECSHD

Bank funds expended to date on project preparation:

1. Bank resources: USD 273,757.43
2. Trust funds: USD 40,197.49
3. Total: USD 313,954.92*

Estimated Approval and Supervision costs:

1. Remaining costs to approval: USD 5,625.20
2. Estimated annual supervision cost: USD 100,000

* Note that a significant share of this expenditure was incurred for preparation of the *Tajikistan Health Sector Note (29858-TJ)* in 2004.

Annex 12: Documents in the Project File

TAJIKISTAN: COMMUNITY AND BASIC HEALTH PROJECT

1. Republic of Tajikistan: Health Sector Note. Report No: 29858-TJ, World Bank, June 30, 2005.
2. Illness Reporting and Access to Health Care among the Poor in Tajikistan. Prepared for the World Bank by Cheryl Cashin, Boston University School of Public Health. April 2004.
3. The Nutrition Situation in Tajikistan. Rae Galloway, World Bank. June 2004.
4. Project Appraisal Document, Tajikistan Primary Health Care. Report No: 19654-TJ, World Bank, February 15, 2000.
5. Tajikistan Community and Basic Health Project: Strengthening Primary Health Care in Sughd and Khatlon Regions, Consultant Report by John Malmborg, March 2005.
6. Health Care Systems in Transition: Tajikistan. European Observatory on Health Systems, 2000.
7. Tajikistan Poverty Assessment, World Bank, 2000.
8. Tajikistan Poverty Assessment Update, World Bank, 2004.
9. Tajikistan Public Expenditure and Institutional Review, World Bank, 2004.
10. Technical Notes, SDC-funded Project Sino, 2004-2005.

Annex 13: Statement of Loans and Credits

TAJIKISTAN: COMMUNITY AND BASIC HEALTH PROJECT

Project ID	FY	Purpose	Original Amount in US$ Millions IBRD	IDA	SF	GEF	Cancel.	Undisb.	Difference between expected and actual disbursements Orig.	Frm. Rev'd
P089566	2005	LAND REGIS & CADASTRE	0.00	0.00	0.00	0.00	0.00	10.29	0.00	0.00
P081159	2004	COMMTY AGRIC & WATERSHED MGMT (GEF)	0.00	0.00	0.00	4.50	0.00	4.30	0.00	0.00
P077454	2004	COMMTY AGRIC & WATERSHED MGMT	0.00	5.00	0.00	0.00	0.00	10.47	-0.50	0.00
P069055	2003	EDUC MOD	0.00	13.00	0.00	0.00	0.00	19.88	1.27	0.00
P008860	2002	POV ALLV 2	0.00	13.80	0.00	0.00	0.00	10.43	1.36	0.00
P057883	2002	DUSHANBE WS	0.00	17.00	0.00	0.00	0.00	14.91	6.78	0.00
P075256	2002	PAMIR PRIV POWER	0.00	10.00	0.00	0.00	0.00	5.11	-6.75	0.00
P067610	2000	LAKE SAREZ RISK MITIGATION	0.00	0.47	0.00	0.00	0.00	0.37	0.26	0.16
P058898	2000	RURAL INFRA REHAB	0.00	20.00	0.00	0.00	0.00	8.55	3.38	-4.09
P059755	1999	IBTA 2	0.00	6.70	0.00	0.00	0.00	0.09	-0.15	-0.32
P049718	1999	FARM PRIV SUPPORT	0.00	20.00	0.00	0.00	0.00	1.34	-2.32	0.03
		Total:	0.00	105.97	0.00	4.50	0.00	85.74	3.33	- 4.22

TAJIKISTAN
STATEMENT OF IFC's
Held and Disbursed Portfolio
In Millions of US Dollars

FY Approval	Company	Committed IFC Loan	Equity	Quasi	Partic.	Disbursed IFC Loan	Equity	Quasi	Partic.
2003	Giavoni	0.00	0.00	3.00	0.00	0.00	0.00	3.00	0.00
2002	Pamir Energy	4.50	3.50	0.00	0.00	0.00	3.50	0.00	0.00
2005	SEF AKFED MB Taj	0.00	0.67	0.00	0.00	0.00	0.00	0.00	0.00
2002/04	SEF FOM	0.50	0.00	0.00	0.00	0.25	0.00	0.00	0.00
2002	SEF Telecom Tech	0.21	0.00	0.00	0.00	0.21	0.00	0.00	0.00
	Total portfolio:	5.21	4.17	3.00	0.00	0.46	3.50	3.00	0.00

FY Approval	Company	Approvals Pending Commitment Loan	Equity	Quasi	Partic.
	Total pending commitment:	0.00	0.00	0.00	0.00

Annex 14: Country at a Glance

TAJIKISTAN: COMMUNITY AND BASIC HEALTH PROJECT

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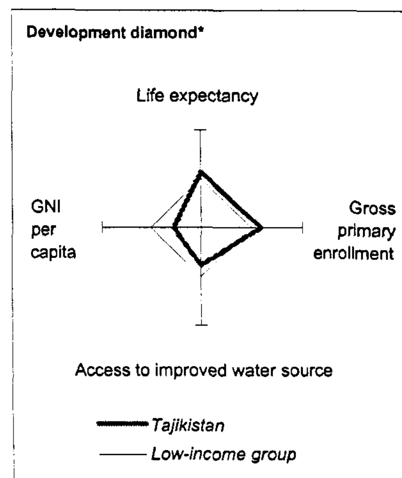
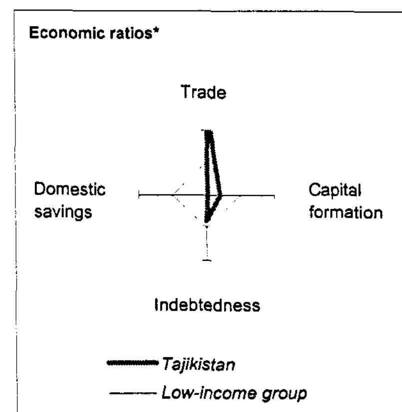
POVERTY and SOCIAL	Tajikistan	Europe & Central Asia	Low-income
2004			
Population, mid-year *(millions)*	6.4	472	2,338
GNI per capita *(Atlas method, US$)*	280	3,290	510
GNI *(Atlas method, US$ billions)*	1.8	1,553	1,184
Average annual growth, 1998-04			
Population *(%)*	0.8	-0.1	1.8
Labor force *(%)*	2.4	-0.5	2.1
Most recent estimate (latest year available, 1998-04)			
Poverty *(% of population below national poverty line)*	..	..	..
Urban population *(% of total population)*	25	64	31
Life expectancy at birth *(years)*	66	68	58
Infant mortality *(per 1,000 live births)*	76	29	79
Child malnutrition *(% of children under 5)*	..	..	44
Access to an improved water source *(% of population)*	58	91	75
Literacy *(% of population age 15+)*	99	97	61
Gross primary enrollment *(% of school-age population)*	111	101	94
Male	113	103	101
Female	108	101	88



KEY ECONOMIC RATIOS and LONG-TERM TRENDS

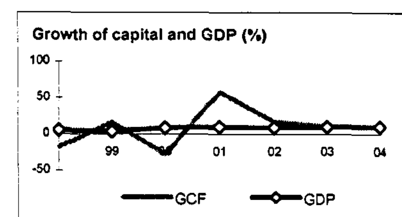
	1984	1994	2003	2004
GDP *(US$ billions)*	..	1.3	1.6	2.1
Gross capital formation/GDP	..	36.5	18.0	9.0
Exports of goods and services/GDP	..	41.6	53.2	54.9
Gross domestic savings/GDP	..	25.0	4.3	-1.0
Gross national savings/GDP	..	26.7	19.7	-4.0
Current account balance/GDP	..	-11.1	1.7	-1.9
Interest payments/GDP	..	0.0	0.9	..
Total debt/GDP	..	43.1	75.1	..
Total debt service/exports	..	0.1	8.4	..
Present value of debt/GDP	..	..	60.4	..
Present value of debt/exports	..	..	88.8	..

	1984-94	1994-04	2003	2004	2004-08
(average annual growth)					
GDP	-7.5	3.8	10.2	10.6	6.1
GDP per capita	-9.9	2.7	9.0	9.4	5.3
Exports of goods and services	..	4.4	6.8	30.7	..

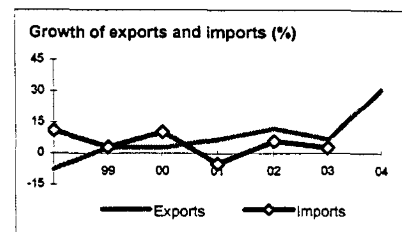


STRUCTURE of the ECONOMY

	1984	1994	2003	2004
(% of GDP)				
Agriculture	..	24.0	23.4	..
Industry	..	41.0	23.6	..
Manufacturing	..	25.8	18.7	..
Services	..	35.0	53.0	..
Household final consumption expenditure	..	55.3	87.4	..
General gov't final consumption expenditure	..	19.7	8.3	..
Imports of goods and services	..	53.1	66.9	64.9



	1984-94	1994-04	2003	2004
(average annual growth)				
Agriculture	-7.8	4.2	9.6	..
Industry	-4.2	2.8	10.2	..
Manufacturing	-2.2	2.7	10.2	..
Services	-4.0	4.6	11.0	..
Household final consumption expenditure	..	7.3	..	..
General gov't final consumption expenditure	..	-7.8	..	..
Gross capital formation	-7.3	-4.8	11.0	..
Imports of goods and services	..	0.8	2.9	..



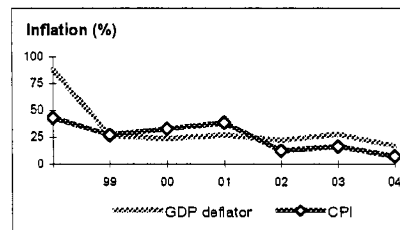
Note: 2004 data are preliminary estimates.

This table was produced from the Development Economics LDB database.

* The diamonds show four key indicators in the country (in bold) compared with its income-group average. If data are missing, the diamond will be incomplete.

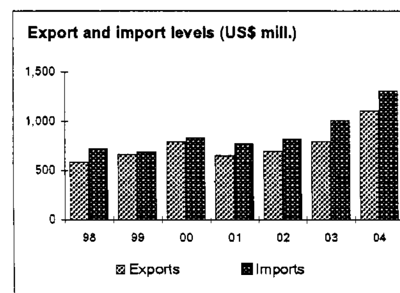
PRICES and GOVERNMENT FINANCE

	1984	1994	2003	2004
Domestic prices				
(% change)				
Consumer prices	..	1.1	16.4	7.3
Implicit GDP deflator	..	221.0	27.9	17.0
Government finance				
(% of GDP, includes current grants)				
Current revenue	..	53.9	17.3	16.6
Current budget balance	..	9.1	4.8	3.3
Overall surplus/deficit	..	-5.2	-1.8	-3.2



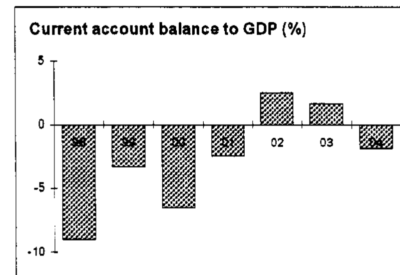
TRADE

	1984	1994	2003	2004
(US$ millions)				
Total exports (fob)	..	559	798	1,108
Aluminum	..	273	430	484
Cotton fiber	..	155	193	202
Manufactures	..	45	54	75
Total imports (cif)	..	686	1,004	1,307
Food	..	99	81	106
Fuel and energy	..	182	159	207
Capital goods	..	67	82	107
Export price index *(2000=100)*	..	97	..	..
Import price index *(2000=100)*	..	102	..	..
Terms of trade *(2000=100)*	..	95	..	..



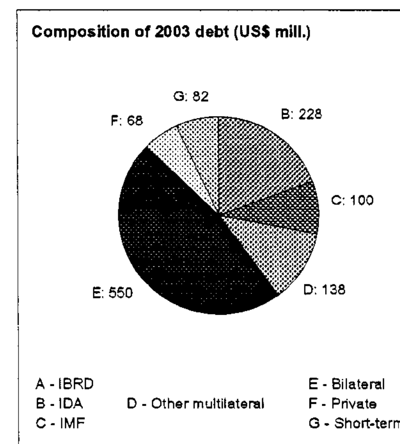
BALANCE of PAYMENTS

	1984	1994	2003	2004
(US$ millions)				
Exports of goods and services	..	560	827	1,140
Imports of goods and services	..	715	1,040	1,348
Resource balance	..	-155	-213	-292
Net income	..	-19	-90	-92
Net current transfers	..	25	329	..
Current account balance	..	-149	26	-40
Financing items (net)	..	148	13	79
Changes in net reserves	..	1	-39	-39
Memo:				
Reserves including gold *(US$ millions)*	..	1	136	184
Conversion rate *(DEC, local/US$)*	..	1.33E-2	3.1	3.0



EXTERNAL DEBT and RESOURCE FLOWS

	1984	1994	2003	2004
(US$ millions)				
Total debt outstanding and disbursed	..	580	1,166	..
IBRD	..	0	0	..
IDA	..	0	228	..
Total debt service	..	0	89	..
IBRD	..	0	0	..
IDA	..	0	2	..
Composition of net resource flows				
Official grants	..	63	78	..
Official creditors	..	177	10	..
Private creditors	..	0	-26	..
Foreign direct investment (net inflows)	..	12	32	..
Portfolio equity (net inflows)	..	0	0	..
World Bank program				
Commitments	..	0	13	..
Disbursements	..	0	13	..
Principal repayments	..	0	0	..
Net flows	..	0	13	..
Interest payments	..	0	2	..
Net transfers	..	0	12	..



Note: This table was produced from the Development Economics LDB database.

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MAP SECTION