PROJECT INFORMATION DOCUMENT (PID)
APPRAISAL STAGE

Report No.: 34019

Project Name	COMMUNITY AND BASIC HEALTH PROJECT
Region	EUROPE AND CENTRAL ASIA
Sector	Health (80%); Compulsory health finance (20%)
Project ID	P078978
Borrower(s)	REPUBLIC OF TAJIKISTAN
Implementing Agency	
	Ministry of Health Health PIU Ibn Sino 30 Str. Tajikistan Tel: 24-44-13
Environment Category	[ ] A [ ] B [X] C [ ] FI [ ] TBD (to be determined)
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1. Country and Sector Background

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 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 suffer one of the poorest health outcomes among the Commonwealth of Independent States, 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 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 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

[1] Poverty line is defined as living below PPP$2 per day. (Tajikistan Poverty Assessment Update, 2004)
[2] National Nutrition Surveys, 2001 and 2002.
[3] Based on comparisons of the TLSS 1999 and TLSS 2003 data.

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 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 infant mortality ~90, child mortality ~120, MMR ~100, TFR ~4.0, TB incidence ~70 and long-term malnutrition among children ~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.

2. Objectives

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. Key indicators would include:

- 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-supported 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.

The Project 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 M&E capacity of MOH, the Project would help MOH 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 BBP—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 in Component C, especially in C2 with its focus 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.

3. Rationale for Bank Involvement

Health is a core objective of the Tajikistan PRSP and improvement in sector performance and health status are key objectives of the government's reform program and efforts to meet the MDGs. The Ministry of Health has demonstrated increasing sophistication over the past few years and is rapidly improving in 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. These bode 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 Bank's second 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 currently awaiting printing and dissemination. The Bank's relationship with MOH and other donors is good and the Bank is respected for its technical input and its coalition-building capabilities. Health also features in the planned PBC operation, with a focus on management and payment reforms in primary care. The current project is mentioned in the CAS on Page 19, Paragraph 61; Page 21, Table 5; Annex B3; and Annex B9.

4. Description

A. Strengthening Policy, Planning and Donor Coordination in the Ministry of Health

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 perform the following analytical functions:

- ③ Monitoring and evaluation of health reforms, concentrating initially on implementation of reforms in primary care and implementation of the Basic Benefit Package;
- ③ 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 amalgam 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.

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, communication programs etc.

B. Implementing Organizational and Financing Reforms in the Health Sector

This component would support the implementation of per capita financing for primary health care and implementation of the Basic Benefit Package. This would require two streams of activity—one in PHC and one in hospitals—and would be carried out initially in the 32 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. 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 BBP. Progress has been made in defining and approving a national guaranteed package of basic health services. The BBP provides a legal framework for developing the co-payment policy that was legalized with the constitutional referendum in 2004. The BBP provides free services for vulnerable population groups and for selected health services. The majority of covered services are in PHC; in hospitals, BBP 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 BBP: so-called "paid services".

- At the hospital level. The subcomponent would provide furniture, computer and 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 for 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 BBP. 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 BBP

and create opportunities for redress in cases of abuse, especially regarding co-payments for paid services.

*B3. Strengthening MOH Oversight of Organizational and Financial Reform*s. 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 BBP; 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 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

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.

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. 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 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 across multiple donors.

D. Project Implementation

This component would finance a Project Implementation Unit consisting of a director, a finance officer, a procurement officer and a procurement assistant. Field supervisors would be hired as local consultants to oversee civil works. As opposed to the current project, component specialists in the new project would, to the extent possible, be co-located with their counterparts in MOH. The PIU would also be located somewhere near the Ministry, recognizing that space limitations prevent full physical integration.

5. Financing

Source:		($m.)
BORROWER/RECIPIENT		0
Sida (Swedish International Development Authority)		6
IDA GRANT FOR POOREST COUNTRY		10
	Total	16

6. Implementation

A key partnership in the current project will be Sida. Sida has agreed to provide significant cofinancing for the project and to delegate project management 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 may also support the sector through separate initiatives such as direct grants to 1-2 NGOs to help strengthen PHC service delivery in Tajikistan. These activities will be closely linked to those anticipated under Component C2 and the Bank will maintain a close correspondence with Sida to ensure complementarity and avoid duplication. A Sida consultant team was appointed on May 10 2005 and will be joining the appraisal mission. Sida specialists will also be invited to join supervision missions at their pleasure, though the responsibility for project implementation will rest with the Bank. A legal agreement establishing a Sida Trust Fund at the Bank to support the project is currently being drafted.

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, 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 Bank's first project and in background studies for the Bank's Tajikistan Health Sector Note that was issued in 2005, and 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 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.

7. 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 Sector-Wide Approach, 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 conduce 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 aims to refine a cost-effective package of investments and service delivery improvements in PHC that can be replicated elsewhere in 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 future application throughout the entire sector rather than for the project alone.

8. Lessons Learned from Past Operations in the Country/Sector

The Tajikistan Primary Health Care Project closed at the end of March (2005). A central component of the project included 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 the 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.

9. Safeguard Policies (including public consultation)

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]

10. List of Factual Technical Documents

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.

11. Contact point

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