PROJECT INFORMATION DOCUMENT (PID)
CONCEPT STAGE

Report No.: AB1279

Project Name	COMMUNITY AND BASIC HEALTH PROJECT
Region	EUROPE AND CENTRAL ASIA
Sector	Health (100%)
Project ID	P078978
Borrower(s)	GOVERNMENT OF TAJIKISTAN
Implementing Agency	
Environment Category	[ ] A [ ] B [X] C [ ] FI [ ] TBD (to be determined)
Safeguard Classification	[ ] S_1 [ ] S_2 [ ] S_3 [ ] S_F [ ] TBD (to be determined)
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1. Key development issues and rationale for Bank involvement

Tajikistan is a country with a weak healthcare system and among the poorest health indicators in the world. Its GDP is US $200 per capita, its government 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, then, some three quarters 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 SAC-3 program 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, but these discussions are at an early stage.

The health policy environment in Tajikistan is yet to mature. There is no 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 limited. This is mirrored in the pattern of donor activity, which until recently was characterized by very 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 improvements on the donor side as well. A joint donor mission on health financing visited Tajikistan in December 2004 and was well-received: similar efforts are likely in future. The proposed 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.

This would be the Bank's second health project in Tajikistan. The ongoing Primary Health Care Project (P04989) is expected to close, fully disbursed, in March 2005, and is currently rated satisfactory. Key lessons from the Project include the political and technical complexity of rationalizing health facilities, especially hospitals; the need for adjustment lending to support institutional reforms such as those in health financing; the need to "anchor" activities in the country's policy or program context to ensure sustainability; and the difficulty of supervising a large number of far-flung civil works to be completed on time and at reasonable cost. On a more positive note, the 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. An ICR mission will visit Tajikistan in February to further evaluate these issues. 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 recent Bank-Fund discussions on health policy issues have been substantive in the context of the upcoming PRGF. Health is a key goal of the Tajikistan PRSP but there is no associated MTEF. Health also features in the ongoing SAC-3 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.

2. Proposed objective(s)

- ③ Improved access to and utilization of PHC in project-supported areas.
- ③ Improved transparency and fairness in financing for health services in Tajikistan.
- ③ Improved patient satisfaction with PHC in project-supported areas.

3. Preliminary description

The Project aims to improve quality of care and access to basic health services for poor and vulnerable populations in Sughd and Khatlon oblasts by upgrading selected primary health care facilities and by supporting organizational and financing reforms in the Tajikistan health sector to strengthen and give added prominence to primary and preventive health care. Four components are envisaged:

Component A. Strengthening Policy, Planning and Management at the Ministry of Health. This component [$1.5 million] would finance three kinds of activities. First, it would finance stage-setting analytical work such as National Health Accounts, a hospital costing exercise, a functional review of the health sector, a human resources study that covers both workforce planning and training issues, a hospital rationalization plan for Sughd and Khatlon oblasts, and an effort to cost the existing state guaranteed package of health services. In doing so it would build the capacity of MOH staff to carry out basic analytical tasks in health policy and planning. Second, it would finance local and international consultants to work with MOH staff to prepare a realistic but comprehensive sector strategy and sectoral expenditure framework—drawing on the analytical work described above—and develop an implementation plan and sector-wide monitoring indicators based on this strategy. This would require extensive consultation with a broad range of stakeholders including *inter alia* MOF, the President's Administration, oblast and rayon health administrators, donor agencies and NGOs. The would be to develop an agreed vision of the health sector that guides government, donor and civil society efforts for a 3-5 year period, and in turn to lay the foundation for Tajikistan to adopt a Sector-Wide Approach to the health sector in 2-3 years. Third, it would finance capacity building efforts for MOH staff—and oblast and rayon health administrators as appropriate—in health policy and planning and monitoring and evaluation. These would be related to the organizational and financing reforms to be supported under Component B, e.g. annual Health Accounts updates or public expenditure tracking surveys to measure actual increases in the PHC budget.

The end result of these activities should be improved leadership, policy-making and management in the health sector and a move toward a Sector-Wide Approach in health founded on agreed sector strategy, a basic MTEF and strong government-led donor coordination. Project supervision could from the outset be arranged in SWAp format, e.g. with twice-yearly "health summits" and efforts to strengthen donor coordination around a common reform program; this would increase the visibility of reform efforts and induce actors such as MOF and the President's Administration to participate more systematically in health policy dialogue, neither of which has been the case to date.

Component B. Implementing Organizational and Financing Reforms in the Health Sector. The government recently embarked on a set of organizational and financing reforms in the health sector. The broad direction of these reforms has been positive: they have included elements of hospital autonomy, basic benefit package development and efforts to strengthen primary care, all of which are appropriate choices for Tajikistan. However, they have also been marked by a hurried and piecemeal approach to implementation and a lack of overall coherence. In some cases this has been due to political pressure; in others it has been due to a lack of technical capacity in the MOH and its inability to design a coherent or realistic reform program or effectively respond to demands from MOF and the President's Administration without just-in-time help from resident donors.

To address these issues, this component [$1.5 million] would help MOH design and implement a coherent—if modest—program of organizational and financing reforms. The program would emphasize two things: first, giving increased prominence and independence to primary care relative to hospital services, both through changes in PHC financing and efforts to improve PHC management at the rayon level; and second, improving the fairness and transparency of payments for health services in general. Specific candidates for support might include scaling-up the state guaranteed package of health services, introducing formal co-payments in hospitals, introducing the family group practice model in primary care and possibly oblast-level pooling of funds for hospital services. These are all consistent with the government's policy directions and are areas where the government has taken initial steps already, e.g. through its decision to adopt capitation-based payments for PHC, its efforts to design and pilot a benefits package and its recent introduction of "paid services" to help formalize informal payments in the hospital sector, among others. The component would therefore finance technical assistance, training, study tours, workshops, equipment and implementation support for MOH and health administrators in oblasts and

rayons where the reform program would initially be implemented. It would also introduce a basic management information system for hospitals and PHC.

Component C. Strengthening Primary Health Care in Sughd and Khatlon Regions. This component [$7 million] would help rehabilitate PHC facilities and unblock bottlenecks to the delivery of PHC services in selected communities in Sughd and Khatlon provinces. A hybrid of centrally-planned and demand-driven approach is proposed, whereby the broad selection of candidate sites is undertaken by MOH and oblast health administrators—based on a rationalization and investment plan being developed under the PHRD grant—but where the final selection of sites is based on proposals submitted by communities, health workers and local health officials together. Proposals would have to account for bottlenecks to the delivery of PHC services in a given area, e.g. "absence of trained staff," "lack of running water at PHC facility," "no local access to drugs," etc. Issues such as pharmaceutical supply and the availability of qualified health workers would be mandatory for all proposals to address; other issues ("our health worker needs a bicycle") would be left for communities themselves to raise. Using objective criteria—including *inter alia* the technical competence and realism of proposals, their consistency with the investment and rationalization plan, their consistency with the envisaged scope of PHC services, and the level of community and health worker involvement in preparing them—grants would be awarded for communities to pursue the activities outlined in their proposals. These would fall under three headings: facilities rehabilitation; meeting core bottlenecks to service delivery; and meeting additional needs.

The component would therefore finance rehabilitation works, technical assistance for proposal preparation, technical assistance for carrying out the rehabilitation works, technical assistance for local health plan implementation and a suitable system of financial controls and audits. A number of these activities could be managed through the existing National Social Investment Fund of Tajikistan (NSIFT) and its well-established system for supporting community development projects. MOH could contract NSIFT as an implementing agency to provide TA for proposal development and administer the evaluation, disbursement and supervision process, though separate firms would be required to provide architectural and engineering TA and to help develop and implement local health plans. The component could also finance basic medical equipment and furniture for rehabilitated facilities, and PHC training for health workers in project areas. Civil works would be supervised "on the ground" by communities, with NSIFT and MOH playing an oversight role and holding final accountability. (Varzob rayon, which is in the Khatlon oblast and received new primary health care facilities under the ongoing Primary Health Care Project, would not receive further investment in civil works or equipment; neither would sites that have been rehabilitated by an ongoing health project of the Asian Development Bank.) With a population of 3 million between them, only a small fraction of Sughd and Khatlon oblasts would be covered by these activities, even assuming modest costs per facility/community; the viability of having such a broad coverage area will be further examined during Project preparation, as will the possibility of having multiple donors use the same approach in different areas.

Component D. Project Implementation. This would finance a Project Implementation Unit consisting of a director, a finance officer, a procurement officer and 1-2 technical specialists as required. To the extent possible, the PIU would be integrated with MOH. A new procurement law is in preparation and is expected to delegate procurement responsibility to ministries' departments of finance and administration: this creates an opening to build fiduciary capacity in MOH, both as an end in itself and in preparation for a future SWAp. This will be investigated during project preparation.

4. Safeguard policies that might apply

The need for an Environmental Assessment will be evaluated during Project Preparation.

5. Tentative financing

Source:		($m.)
BORROWER/RECIPIENT		0
INTERNATIONAL DEVELOPMENT ASSOCIATION		8
IDA GRANT FOR POOREST COUNTRY		1
IDA GRANT FOR HIV/AIDS		1
	Total	10

6. Contact point

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