1. Key development issues and rationale for Bank involvement

i) Sector Background

Several health sector sub-strategies exist in Tajikistan\(^1\) that all highlight the need for (i) health financing reforms, (ii) hospital restructuring; (iii) human resource planning and training, (iv) quality of care, accreditation and licensing, (v) priority disease programs to support MDGs, and (vi) information, including public health, prevention and community work. These are also the six reform priority areas of the Ministry of Health. The goal of these different strategies and policies are all to improve access to better quality health care services, efficiency and financial sustainability. These goals are consistent with the Government objectives identified in the National Development Strategy of the Republic of Tajikistan for the period until 2015, the Poverty Reduction Strategy 2007 – 2009, and the Strategy on Health Care by 2010 (Chapters 1-3). The implementation of the strategic and policy reform has started and is led by the Government with the support of various donors including ADB, SDC, SIDA, WHO and other UN agencies, ZdravReformPlus/USAID, and the World Bank. Implementation has focused on health policy formulation and analytical capacity building at the MOH, public health and community information campaigns, training of health personnel to improve quality and modernize the provision of care, investment in infrastructure and medical equipment in PHC centers and rayon hospitals, provider payment reform for PHC and basic benefit package definition in hospitals linked with the attempt to formalize informal payments. While progress is made, most of these activities are still limited to a rayon or pilot level. There is a need for continuous evaluation, adjustment and successive scaling-up of what has been successful to the rest of Tajikistan. Overall, the sector is still characterized by poor health outcomes, misallocation of staff and other resources ensuing inefficient production of care, hospital overcapacities, limited capacity for policy formulation, and severe under-funding. Compared to other countries at similar level of GDP, Tajikistan has a large number of hospital beds (612 beds per 100,000 population in 2006) which are unequally distributed between urban and rural areas. These sector weaknesses have resulted in inequity in access and insufficient quality of care.

---

In 2005, government spending on health was at 1.1 percent of GDP, while total health spending was estimated at 4.6 percent of GDP\(^2\). While donors contribute about 13 percent and the government 16 percent of total health spending, patients finance out-of-pocket 73 percent of total health expenditures, which is the highest share in the entire European and Central Asia Region. In a context with extremely low salaries and limited availability of accounting systems in health facilities, patient payments are informal payments to health staffs who keep the money for salary mark-ups. As a consequence of these extremely high informal payments, persistent poverty and limited government leadership in the health sector, a large proportion of the population has limited access to care, contributing to relatively high maternal mortality rates and a low health-adjusted life expectancy (HALE) (see Figures 1 and 2).

**Figure 1: Maternal mortality**

![Maternal mortality graph]

---

**Figure 2: Health-adjusted life expectancy**

![Health-adjusted life expectancy graph]

---

is also supported by two multi-sectoral operations, the PDPG policy loan, and the public sector wage reforms, which both provide substantial synergies to an additional health operation and vice-versa. Several AAAs are ongoing, including a PETS and MCSA as well as a UNICEF supported household survey on access to care for mother and children; all of them will support the monitoring and evaluation process of a future Bank operation. Relatively poor health indicators combined with a need for modernizing the provision of care, human resource and health financing reforms highlight the importance for continued support to the health sector. The proposed project is also included in the Tajikistan CAS (Table 2).

iii) Rationale for the Sector Wide Approach or a Traditional Health Project in the Health Sector

The two previous projects in the health sector were implemented though the traditional projects approach. Both projects are rated as satisfactory. A coordinated and open dialogue between the Government and donors is fostered under the current CBHP, which is co-financed by SIDA (Sweden) and SDC (Switzerland) and collaborates closely with WHO, UNICEF, ADB and ZdravReform (USAID). This collaboration is continuing to contribute to human and infrastructure capacity building in the health sector and at the Government. Reforms are pilot-tested and evaluated and results discussed and used for revisions and expansions.

Several health donors, including ADB, SIDA and USAID are currently in the process of reassessing their future involvement in health. Switzerland is the only donor with a health project in the pipeline (US$6.5 over 3 years). The EC will most likely focus on health management information systems (HMIS) as of 2009. USAID will most likely continue to provide technical support to health financing reforms; SIDA is considering closing down all activities in health over the next year, but offered to provide support to the strategy development as needed.

A new WB health operation is expected to ensure continuity in collaboration with the Government on major strategic sub-components and support the implementation of other cross-sectoral Bank programs including the PDPG and public sector wage reform. The ongoing MTBF and fiduciary assessment as well as the presence of several sub-strategies and the intention to prepare a comprehensive health sector strategy are providing the necessary building blocks to develop and implement a new health operation. The context of very weak governance and the recent fraud involving the IMF are not conducive to a pooled-funding operation. It is expected that a parallel-funded operation under a SWAp could contribute to a coordinated and open policy dialogue for the entire sector, strengthening of the country’s capacity, systems and institutions at a feasible pace and phasing and a greater focus on results. However, the past experience with the CBHP has shown that these objectives can also be achieved under a traditional health project presumably at lower costs related to donor coordination, with all donors working under the same strategy.

2. Proposed objective(s)

The overall objective of the project will be to improve the health status of the population through improvements in the performance of the health sector, focusing on financial sustainability and efficiency in health care financing and production. Indicators are to be developed during the project preparation. The specific objective of the project will be:

Improved financial sustainability, efficient use of human resources and access to better quality health care
3. Preliminary description

The new Bank project will support the process of strategy formulation and the implementation of related sub-strategies in line with the Bank’s comparative advantages as outlined in the new WB health sector strategy. The project would therefore finance a 5-year Program of Work designed around the objectives of the development and implementation of a comprehensive sector strategy, and an expected focus on three of the MoH six priority areas: (i) health financing reform, (ii) hospital restructuring, and (iii) human resource reform. A PHRD grant has been applied for to finance technical support to the comprehensive health sector strategy development.

Component 1: Develop and implement sustainable health financing reforms: This component (US$4 million) will build up on financing reform started under the ongoing CBHP (hospital BBP and capitation payment reform). In close collaboration with USAID and other donors, it will support the scale up of reforms that have been proofed successful in pilot tests and support health financing reforms as outlined in the Government strategy. The focus will be on scaling up capitation payment for PHC, the benefit package in hospitals and formalizing informal payments.

Component 2: Rationalize the hospital sector: This component (US$5 million) will finance the development of a hospital rationalization plan (Masterplan) that improves the efficient allocation of modern hospital care across the country. Thereby, it will support the implementation of the 2006 national program for strengthening primary health care, reducing the number of hospital beds and introduction of family physicians model with the latter being supported under CBHP. Building up on work started under the CBHP, a hospital Masterplan with detailed implementation plans will be developed to improve access to care and efficient allocation of resources. A selected number of hospitals will be restructured and modernized following the Masterplan recommendations.

Component 3: Human resource reform in health sector: This component (US$1 million) will support an analysis of the current human resource allocation in the health sector and develop a sub-strategy for HR capacity improvement. Implementation of action plans will support the ongoing public sector wage reform process, improve efficient allocation of staff and support the continuous education of medical personnel, including adherence to modern treatment protocols.
4. Safeguard policies that might apply

-None-

[Guideline: Refer to section 5 of the PCN. Which safeguard policies might apply to the project and in what ways? What actions might be needed during project preparation to assess safeguard issues and prepare to mitigate them?]

5. Tentative financing

<table>
<thead>
<tr>
<th>Source</th>
<th>($m.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>BORROWER/RECIPIENT</td>
<td>0</td>
</tr>
<tr>
<td>IDA Grant</td>
<td>10</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10</strong></td>
</tr>
</tbody>
</table>

6. Contact point
Contact: Pia Helene Schneider
Title: Sr. Health Economist
Tel: (202) 458-9328
Fax:
Email: Pschneider@worldbank.org