I. Introduction and Context

Country Context

Tajikistan is a small landlocked country in Central Asia with an estimated population of 7 million in 2009. While it is blessed with abundant water resources, contributing to its specialization in cotton production, Tajikistan is vulnerable to natural disasters and external economic conditions. Only 7 percent of its total land area is arable; high mountain ranges make communication between different parts of the country difficult, especially in winter. Tajikistan is susceptible to natural disasters and is regularly affected by floods, landslides, earthquakes, and droughts. These factors contribute to making Tajikistan one of the world's poorest and most vulnerable economies.

Tajikistan's gross national income (GNI) per capita was estimated at US$700 in 2009, the lowest in Central Asia. Limited employment opportunities at home have 40 percent of the working age population seeking better jobs in Russia. Shortly after its independence in 1991, the country descended into a civil war that lasted until mid-1997, and which brought widespread physical damage and loss of life. Poverty rates in Tajikistan have declined significantly from 72.1 percent in 2003 to 53.1 in 2007 and even further to 47.2 percent in 2009. Poverty is mainly a rural phenomenon, with the rural poor accounting for 75 percent of all poor and 72 percent of the extreme poor.

Sectoral and Institutional Context
Maternal and Child Health (MCH) outcomes in Tajikistan are among the worst in the region; especially Infant Mortality (IMR), Under Five Mortality, and Maternal Mortality (MMR). As such Millennium Development Goals (MDG) 4 & 5 targets are unlikely to be attained within the next 4 years. Rates of malnutrition and micronutrient deficiencies are high, with 29 percent and 53 percent of children aged 6 to 59 months respectively, stunted and iodine deficient. Preventable illnesses contribute to a considerable proportion of all child deaths in Tajikistan. Acute infections are the leading cause of deaths in the post-neonatal period. Acute respiratory illness (ARI), pneumonia, and acute diarrhea still account for more than 50 percent of reported child deaths within the first year of life, a pattern that has remained persistent over the last eight years until the present. Physical distance to health facilities is also an important barrier for women to access antenatal and other health services, especially for those in rural areas.

The distribution of years of life lost (YLL) by causes in the year 2008 show that communicable diseases represent 62 percent of the total YLL, followed by non communicable diseases (NCDs) with 32 percent and injury 6 percent. However, cardiovascular diseases (ischemic heart disease, followed by hypertensive heart disease and cerebrovascular disease) represent the largest cause of death, followed by malignant neoplasms, respiratory diseases and diabetes mellitus. The coverage of priority MCH and Reproductive Health services in Tajikistan is low. This is also true for critical areas such as behavior change communication for nutrition, which is an important problem for children under the age of five. Only 64 percent of under-fives with suspected pneumonia were taken to an appropriate health care provider, while only 41 percent of under-fives with suspected pneumonia received any antibiotics. Coverage rates for key MCH services are much lower in rural than urban areas.

Tajikistan's health system is focused largely on curative in-patient services to the disadvantage of Primary Health Care (PHC). PHC is not only the stepping stone of the health care system but also the first point of contact particularly for the rural and poor population. The current health system de-prioritizes PHC, lacks a results focus and fails to motivate health workers to perform well. At 5.3 percent of the GDP (2007), overall health spending is low. A relatively small proportion of the health budget (36 to 37 percent) is allocated to PHC. Furthermore, there are wide disparities in PHC spending by rayons (districts) with the poorest rayons spending the least. The health system lacks a results focus as resource allocation is based on inputs and providers are not held accountable for results. PHC health workers are underpaid and there are few mechanisms to motivate them to perform better. PHC facility managers have little management autonomy and many facilities do not have several of the key inputs (such as basic drugs, equipment and other supplies) that health workers need to deliver appropriate and quality care to the population. Over the last decade, Tajikistan has been reforming its health care system to address these inter-related issues that contribute to poor population health outcomes and health system performance.

Pilot reforms have laid the groundwork to prioritize PHC and reform payment systems but much remains to be done. Key reforms that have or are being implemented on a pilot basis in selected rayons include the introduction of a basic benefits package (BBP)- wherein a limited number of PHC services are free and some hospital and diagnostic services have formal co-payments with some exemptions, introduction of partial capitation-based financing for PHC, building management capacity, introduction of the Family Medicine (FM) model of practice, clinical capacity building of PHC physicians and nurses in FM and rehabilitation of PHC physical infrastructure. While these have led to some improvements in PHC service delivery, there are still several issues to be addressed.

At the same time, critical gaps persist in the quality of care. Despite the many efforts to improve the financing, capacity and physical infrastructure at the PHC level, in the absence of incentives to providers these have not translated into better service quality. Results Based Financing (RBF) strategies have successfully improved coverage and quality of care in other contexts. RBF schemes have achieved remarkable results in health service delivery and health outcomes in various contexts with diverse health systems-low and high income, as well as fragile states. RBF is defined as "a cash payment or non-monetary transfer made to a national or sub-national government, manager, provider, payer or consumer of health services after predefined results have been attained and verified. Payment is conditional on measurable actions being undertaken(8)."

In addition a combination of both supply (provider) and demand (population) side interventions in RBF could enhance results. Demand-side approaches such as provision of vouchers, cash or in-kind payments have also been successfully used in other countries to motivate households to use key health services. These interventions which can be implemented alone or in parallel with an incentive scheme to health providers, reward households for completing specific health-related actions such as delivering in a health facility or compliance with the DOTS treatment program.

Relationship to CAS

The proposed new health operation is consistent with the objectives of the Tajikistan’s Country Partnership Strategy (CPS) for FY 2010-13 as follows:

Objective I: reducing the negative impact of the crisis on poverty and vulnerability; Result 2, maintain access to health services particularly for the poor and vulnerable. As indicated in the CPS the insufficient and inequitable allocation of public resources to the health sector, together with the exodus of workers overseas due to limited job opportunities and low wages in the country, have led to an acute shortage of financial and human resources in the health sector and thus to a lowering of access to health services.

Objective II: pave the way for post-crisis recovery and sustained development; Result 8, enhance human capital potential strengthening the quality of health care. As noted in the CPS, the strengthening of Tajikistan’s stock of human capital has significant positive implications for medium-term growth. In this regards, a critical area identified in the CPS and supported by the proposed operation is to overcome the outdated input-based budget formation and resource allocation processes, which derive from the Soviet system and tend to maintain unaffordable hospital infrastructure capacity and prevent a shift to a more cost-effective PHC.
9. Additionally the proposed operation is consistent with the crosscutting initiatives identified as crucial to support CPS objectives. Those are: (i) Result 9, strengthen incentives for better performance of civil servants: an RBF-type approach will promote and support a more efficient and effective health service delivery system; and (ii) Result 10, strengthen transparency and accountability in public financial managements: by supporting citizen involvement and oversight in the delivery of public health services. Finally, by focusing on gender specific health needs, such as maternal and child health, the proposed operation will support CPS objective aimed at mainstreaming efforts to address gender disparity.

II. Proposed Development Objective(s)

Two formulations of the PDO are currently under consideration:

Option 1: To contribute to the improvement of coverage and quality of a basic package of PHC services in rural health facilities.

Option 2: (i) To contribute to the improvement of coverage and quality of a basic package of PHC services in rural health facilities through an RBF approach; and (ii) To build the capacity of the Government of Tajikistan and health providers to deliver a basic package of PHC services.

Key Results

Possible PDO indicators under consideration include the following:

i) The percentage of children aged 12-23 months fully immunized;  
ii) The percentage of pregnant women receiving antenatal care four or more times during pregnancy.  
iii) The percentage of PHC providers following updated clinical treatment protocols for IMCI  
iv) The percentage of patients aged 40 and older screened for hypertension;  
v) Proportion of health facilities that achieved [SPECIFIC] percentage of their performance targets in the preceding quarter;  
vii) Proportion of health facilities that received timely payments for performance in the preceding quarter;  
vii) The number of health facilities that received MCH equipment;  
viii) The number of health workers that received MCH training.

III. Preliminary Description

The project aims to contribute to (i) an increase in coverage of a basic package of PHC services through Results Based Financing (RBF), and (ii) an improvement in the quality of care for this package of PHC services through RBF and traditional input-based support in project-supported rural districts. In this proposed RBF program provider payments (i.e., to health facilities) would be introduced on a fee for service basis with adjustments for technical quality (See Musgrove, 2011). The package of PHC services would be defined based on health sector priorities and would include MCH, communicable and non-communicable disease services that can be delivered at the PHC level. It is expected that a total of at least eight to ten rayons would be included in the project, with the initial focus on implementing a supply side intervention given the more pressing problem of the quality of services. If necessary, the project might later expand to include a demand side intervention as well. The feasibility of such an approach within the context of Tajikistan would be explored during the project preparation phase.

13. Preliminary Project Design. The project would have three components:

Component 1: Results Based Financing: This component would support the implementation of RBF in health facilities and would thereby create incentives to improve coverage and quality of care for the incentivized health services.

Component 2: Capacity building for PHC: This component would support capacity building at the PHC level and would contribute to improvements in quality of care.

Component 3: Project management: This component would cover the management costs of the project. More details on the three components are provided subsequently.

14. In addition, since Results Based Financing (RBF) is an innovative approach that has not been systematically implemented in the Tajikistan health sector before, a key objective of the project is to undertake a rigorous Impact Evaluation (IE) to determine whether RBF is an effective strategy to improve the coverage and quality of a basic package of primary care services in the Tajikistan context.

IV. Safeguard Policies that might apply

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V. Tentative financing

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