Report and Recommendation of the President to the Board of Directors

Project Number: 51010-002
November 2018

Proposed Grant
Republic of Tajikistan: Maternal and Child Health Integrated Care Project

Asian Development Bank

CURRENCY EQUIVALENTS
(as of 7 November 2018)

Currency unit	–	somoni (TJS)
TJS1.00	=	$0.1061492246
$1.00	=	TJS9.4207

ABBREVIATIONS

ADB	–	Asian Development Bank
BCC	–	behavior change communication
CME	–	continuous medical education
EIRR	–	economic internal rate of return
EMP	–	environmental management plan
GIZ	–	Deutsche Gesellschaft für Internationale Zusammenarbeit
IEE	–	initial environmental examination
KAP	–	knowledge, attitude, and practice
MCH	–	maternal and child health
MOHSPP	–	Ministry of Health and Social Protection of the Population of the Republic of Tajikistan
PAG	–	project administration group
PAM	–	project administration manual
PHC	–	primary health care
SDG	–	Sustainable Development Goal
UNICEF	–	United Nations Children's Fund

NOTE

(i) In this report, "$" refers to United States dollars.

Vice-President	Wencai Zhang, Operations 1
Director General	Werner Liepach, Central and West Asia Department (CWRD)
Director	Rie Hiraoka, Social Sector Division, CWRD
Team leader	Rouselle Lavado, Senior Health Specialist, CWRD
Team members	Ana Paula Araujo, Environment Specialist, CWRD Madeline Dizon, Associate Project Analyst, CWRD Firuza Dodormirzoeva, Project Assistant, Tajikistan Resident Mission, CWRD Rose Anne Dumayas, Operations Assistant, CWRD Eiko Izawa, Unit Head, Project Administration, CWRD Patricia Rhee, Senior Counsel, Office of the General Counsel Mary Alice Rosero, Social Development Specialist, CWRD Yukihiro Shibuya, Social Development Specialist, CWRD
Peer reviewer	Eduardo Banzon, Principal Health Specialist, Sustainable Development and Climate Change Department

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PROJECT AT A GLANCE

1. Basic Data — **Project Number:** 51010-002

Project Name	Maternal and Child Health Integrated Care Project	**Department /Division**	CWRD/CWSS
Country	TAJ	**Executing Agency**	Ministry of Health and Social Protection of the Population of the Republic of Tajikistan
Borrower	Ministry of Finance		

2. Sector	**Subsector(s)**	**ADB Financing ($ million)**
✓ **Health**	Health sector development and reform	32.00
	Total	**32.00**

3. Strategic Agenda	**Subcomponents**	**Climate Change Information**	
Inclusive economic growth (IEG)	Pillar 2: Access to economic opportunities, including jobs, made more inclusive	Climate Change impact on the Project	Low

4. Drivers of Change	**Components**	**Gender Equity and Mainstreaming**	
Governance and capacity development (GCD)	Institutional systems and political economy	Gender equity (GEN)	✓
Knowledge solutions (KNS)	Application and use of new knowledge solutions in key operational areas Knowledge sharing activities Pilot-testing innovation and learning		
Partnerships (PAR)	Bilateral institutions (not client government) Implementation		

5. Poverty and SDG Targeting		**Location Impact**	
Geographic Targeting	Yes	Rural	High
Household Targeting	No		
SDG Targeting	Yes		
SDG Goals	SDG3		

6. Risk Categorization: Low

7. Safeguard Categorization **Environment:** B **Involuntary Resettlement:** C **Indigenous Peoples:** C

8. Financing

Modality and Sources	**Amount ($ million)**
ADB	**32.00**
Sovereign Project grant: Asian Development Fund	32.00
Cofinancing	**0.00**
None	0.00
Counterpart	**3.20**
Government	3.20
Total	**35.20**

Currency of ADB Financing: USD

Source: Asian Development Bank

I. THE PROPOSAL

1. I submit for your approval the following report and recommendation on a proposed grant to the Republic of Tajikistan for the Maternal and Child Health Integrated Care Project.

2. The project supports Tajikistan's commitment to attaining Sustainable Development Goal 3 (SDG 3) and in particular its targets for maternal and child health (MCH). The project will help integrate MCH services at the primary and secondary levels to deliver better quality of healthcare in three districts with the highest rates of maternal and child mortality.[1]

II. THE PROJECT

A. Rationale

3. Tajikistan is a small, landlocked country located in the southeastern region of Central Asia. Its territory covers 142,600 square kilometers and is bordered by Uzbekistan and the Kyrgyz Republic to the west and north, the People's Republic of China to the east, and Afghanistan to the south. It is a low-middle income country with a gross national income per capita of $1,110; a population of 8.7 million; and a poverty headcount rate of 31.3%.[2]

4. Tajikistan is committed to the attainment of SDG3 targets for neonatal and infant mortality —12 neonatal and 25 infant deaths per 1,000 live births. The country's current child mortality rates are 20 neonatal deaths per 1,000 live births and 37 infant mortality rate.[3] Maternal mortality also is higher in Tajikistan—32 deaths per 100,000 live births in 2017—than in other Central Asian or European countries, which averaged 23 deaths per 100,000 live births in 2017.[4]

5. The attainment of the MCH-related SDG3 targets is constrained by systemic health sector issues such as inadequate funding for and delivery of quality health care services, insufficient human resources, and the population's limited awareness of the importance of MCH. Other impediments to MCH outcomes outside the health sector are poverty, geography, and lack of access to clean water.

6. Achieving better health for all is an important part of Asian Development Bank's (ADB) Strategy 2030 which aims to address remaining poverty and reducing inequalities in Asia and the Pacific. The strategy regards ADB's support for improving quality and coverage of health services and reducing the out-of-pocket expenses incurred by the poor as essential in addressing impoverishment.

7. **Health services delivery.** MCH care suffers from fragmented links and communication between primary health care (PHC) and hospital care, nonfunctioning referral pathways, and an absence of patient follow-up practices. Apart from being fragmented, the service delivery system is duplicative. For instance, antenatal care, immunization, and child health care are provided at

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[1] To select the districts, Ministry of Health and Social Protection of the Population of the Republic of Tajikistan and ADB developed a three-step process that included ranking of district using indicators depicting MCH continuum of care and socio-economic status, exclusion of districts with significant donor presence, and identifying readiness for reforms through focus group discussions and surveys. Criteria for Selection of Project Districts (accessible from the list of linked documents in Appendix 2).

[2] Current US$, Atlas method. World Bank. 2018. World Development Indicators.

[3] United Nations International Children's Emergency Fund (UNICEF). 2018. Monitoring the situation of Women and Children.

[4] UNICEF. 2018. Monitoring the situation of Women and Children, and World Bank. World Development Indicators.

PHC centers. Alongside these are specialized institutions such as the Center for Immunization and the Center for Integrated Management of Childhood Illnesses, which can also provide consultations on MCH. These specialized centers are vertical programs that directly report to the Ministry of Health and Social Protection of the Population of the Republic of Tajikistan (MOHSPP). Some of them also provide limited inpatient care.

8. Most patients go directly to secondary- and tertiary-level hospitals, bypassing most rural hospitals for child delivery and during child illness. Bypassing leads to disrupted patient care and a more expensive health service delivery. Although regulations on a referral system exist, its implementation is not enforced.

9. Health facilities in remote districts are in poor condition after years of underinvestment, and available technology and equipment are often obsolete. About 65% of the facilities were built between 1938 and 1990, and most do not meet basic technical requirements and put both patients and staff at risk.[5] Some lack electricity during winter, many have inadequate sanitation, and infection-preventing measures are not always adhered to.[6]

10. **Human resources for health.** The poor qualifications of health care workers are another constraint. In a small-scale study of selected health care providers in rural areas, physicians and midwives on average answered less than 50% of 52 knowledge questions about maternity care correctly.[7] Continuous medical education (CME) is regulated by a special decree. Publicly financed slots are scarce, and neither the health facilities nor the physicians can afford to pay for training. Demand for paid CME courses is low unless they are financed by development partners.[8] The quality of care has also suffered from a serious brain drain, beginning with the civil war and continuing into the present, as health workers seek higher wages abroad.

11. **Health financing.** All the problems above are exacerbated by limited financing for health. Despite the political commitment to public health,[9] the health sector commands only 7.0% of the total government budget, compared with 12.0% in the Kyrgyz Republic and an 11.5% global weighted average.[10] Consequently, households' shoulder most of the health care costs.[11]

12. A World Bank review of public health expenditure noted an oversupply of beds and too many avoidable inpatient admissions (an estimated one-third of these cases could have been treated in outpatient settings).[12] This situation is compounded by the current health financing modalities, whereby the government provides funds through line-item budgeting, which allocates public funds to institutions based on their bed capacity, number of staff, and historical utility costs.

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[5] KfW. 2013. *Strategic Plan for the Rationalization of Hospital Care in the Khatlon Oblast*. Tajikistan.

[6] B. Matthys. 2014. *Quality of care assessment in primary health care facilities in two new pilot rayons of Project Sino V and comparison with findings from the 2012 assessment*. Basel: Swiss Centre for International Health and Swiss Tropical and Public Health Institute.

[7] T.A. Wiegers, W.G.W. Boerma, O. de Haan. 2011. Maternity care and birth preparedness in rural Kyrgyzstan and Tajikistan. *Sexual and Reproductive Healthcare*. Vol. 1: pp. 189–194.

[8] The decree instructs physicians to collect a certain amount of credit hours in order to be certified or recertified once every 5 years.

[9] Address by the President of the Republic of Tajikistan, the Leader of the Nation, H.E. Emomali Rahmon to the Parliament of the Republic of Tajikistan, 22.12.2017, Dushanbe City. http://www.president.tj/en/node/16773.

[10] World Bank. World Development Indicators.

[11] Data from the 2015 Tajikistan health accounts show that 63.3% of total health expenditures are met by households' out-of-pocket payments.

[12] World Bank. 2013. Tajikistan Public Expenditure Review.

In contrast, many countries have shifted to a case-based payment system, which reimburses hospitals at a predetermined fixed rate for each treated case.[13]

13. **Knowledge of maternal and child health.** The share of pregnant women delivering in hospitals has steadily increased in Tajikistan's urban centers, but in rural and often remote areas, awareness of the need for timely and good-quality MCH care remains low. Limited access to hospitals and cultural issues are only part of the story. The rural population also lacks important information on childcare practices. A coherent and culturally sensitive strategy to change the health-seeking behavior of rural families does not exist, and rural health workers also lack the skills to communicate effectively with these communities.

14. **Government's sector strategies.** The pursuit of SDG3 is echoed in the National Health Strategy for Tajikistan, 2010–2020, which envisions strengthening maternal, newborn, child, and adolescent health; preventing and controlling infectious diseases; decreasing the burden of preventable noncommunicable diseases; and improving PHC. The government approved the Strategic Plan for the Rationalization of Medical Facilities in the Republic of Tajikistan for 2010–2020 (No. 169 dated 1 April 2011) to rationalize health service delivery. The plan envisions the integration of health services across levels of care and types of providers.

15. **Lessons.** The project will build upon achievements and lessons learned from ADB's past support to health sector in Tajikistan. A major lesson learned from the Health Sector Reform Project is that rationalization of health facilities and provision of adequate health financing should go hand in hand.[14] The completion report noted the value of conducting comprehensive needs assessment before drawing up civil works and equipment lists to ensure right inputs are made, and the need for intensive information campaigns to ensure community participation.

16. **ADB value addition**. ADB will contribute to the integration of primary and secondary care by concentrating on MCH, which is key for better-quality and efficient provision of services. The project will consolidate different pilots of development partners that focus on either PHC or secondary care into an integrated concept. Integrated care refers to integration and coordination of all levels of health services (primary, secondary, and tertiary) to provide patients with more effective and continuous care.[15] ADB will bring in regional lessons on integrating health care services and improving efficiencies in health service delivery to inform the project and the country's ongoing health reforms.

17. **Development partner support**. German development cooperation through KfW has been supporting the rationalization of hospitals in Khatlon Oblast since 2011, while the World Bank, the Japan International Cooperation Agency, and German development cooperation through Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) have been supporting PHC. United Nations agencies such as the World Health Organization, the United Nations Children's Fund (UNICEF), the United Nations Development Programme, and the United Nations Population Fund are also providing policy and implementation support to the sector. KfW's planned financing of the Mother, Child and Emergency Care VI program will align with the project to complete the continuum of MCH care: the ADB project focuses on primary and secondary care,

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[13] J. Langenbrunner, C. Cashin, and S. O'Dougherty. 2009. *Designing and Implementing Health Care Provider Payment Systems: How-To Manuals*. Washington, DC: World Bank.

[14] Asian Development Bank. 2010. *Project Completion Report*: *Tajikistan Health Sector Reform Project* (Loan 2054-TAJ). Manila: Philippines.

[15] S. Shaw, R. Rosen, and B. Rumbold. 2011. *What is integrated care?: An overview of integrated care in the NHS*. London. https://www.nuffieldtrust.org.uk/files/2017-01/what-is-integrated-care-report-web-final.pdf.

while the new KfW program supports the tertiary reference level for ADB project districts. Close coordination is planned on a case-based payment system pilot and the implementation of a national medical equipment maintenance concept.[16]

B. Impact and Outcome

18. The project is aligned with the following impact: improved health status and well-being of mothers and children in the project districts.[17] The project will have the following outcome: improved coverage of women and children with quality MCH services in the project districts.[18] Project districts are: Fayzobod, Rasht and Shamsiddin Shohin.[19]

C. Outputs

19. **Output 1: Integrated delivery of quality maternal and child care services in project districts improved.** The project will: (i) formulate a strategy for planning and deploying human resources, build institutional capacity for CME; and strengthen clinical capacities in the project districts; (ii) create an effective referral system between the various MCH service levels as well as a sound feedback mechanism and integration of vertical programs into PHC; (iii) institutionalize continuous quality improvement (CQI) system at national, sub-national and facility levels and establish a supportive supervision system; and (iv) pilot case-based payment system at project district hospitals.[20]

20. **Output 2: Infrastructure and equipment for MCH services in project districts rationalized and improved.** The project will support: (i) upgrade of central district hospitals (CDHs) and DHCs; (ii) supply of medical equipment and medical furniture to refurbished CDHs and DHCs, and provision of basic medical kits to PHC facilities; and (iii) piloting of the equipment management system in project facilities. The project will also support the Government's efforts in establishing a national equipment management system in close coordination with KfW and JICA.

21. **Output 3: Knowledge of MCH and health seeking behaviors in project districts improved.** The project will help (i) build the capacity of the Republican Healthy Lifestyle Center for developing a behavior change communication (BCC) plan, and for monitoring, evaluating, and reporting the plan; (ii) design and implement district-specific knowledge, attitude, and practice (KAP) surveys; and design district-specific BCC implementation plans based on the findings of the baseline KAP survey; (iii) carry out community mobilization activities to promote social norms that support collective MCH objectives and challenge harmful practices; and (iv) develop the BCC skills of health workers and community members.

D. Summary Cost Estimates and Financing Plan

22. The project is estimated to cost $35.2 million (Table 1). Detailed cost estimates by expenditure category and by financier are in the project administration manual (PAM).[21]

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[16] A memorandum of understanding between ADB and KfW was signed on October 17, 2018.
[17] Government of Tajikistan. 2017. *National Development Strategy*. Dushanbe.
[18] The design and monitoring framework is in Appendix 1.
[19] The population in project districts are 93,400 for Fayzobod, 115,200 for Rasht, and 50,700 for Shamsiddin Shohin. Criteria for Selection of Project Districts (accessible from the list of linked documents in Appendix 2).
[20] Case-based Payment System Pilot (accessible from the list of linked documents in Appendix 2).
[21] Project Administration Manual (accessible from the list of linked documents in Appendix 2).

Table 1: Summary Cost Estimates
($ million)

Item		Amount
A.	**Base Cost**	
	1. Output 1: Integrated delivery of quality maternal and child care services in project districts improved	3.10
	2. Output 2: Infrastructure and equipment for maternal and child health services in project districts rationalized and improved	21.50
	3. Output 3: Knowledge on maternal and child health and health seeking behaviors in project districts improved	1.00
	Project implementation	33.70
	Subtotal (A)	**29.30**
B.	**Contingencies (B)**	**5.90**
	Total (A+B)	**35.20**

Notes:
1. Includes taxes and duties of $3.3 million of which the Asian Development Bank will finance $0.13 million.
2. All government counterpart funding will be in tax and duty exemptions, estimated to be $3.2 million.
3. In 2018 prices as of August 2018.
4. Physical contingencies computed at 10% for civil work and 5% for other goods and services. Price contingencies are based on escalation rates for domestic and international costs estimated for Tajikistan. The annual escalation rate for domestic costs is estimated to average 7% per year, while the annual escalation rate for international costs is estimated to average 1.5% per year.
Source: Asian Development Bank estimates.

23. The government has requested a grant not exceeding $32,000,000 from ADB's Special Funds resources (Asian Development Fund) to help finance the project.[22] The grant will finance civil works, goods, consulting services, and project implementation and monitoring. The government will contribute in-kind assistance in the form of tax exemptions (and other in-kind contributions). The tentative financing plan is in Table 2.

Table 2: Summary of Financing Plan

Source	Amount ($ million)	Share of Total (%)
Asian Development Bank		
Special Funds resources (Asian Development Fund grant)	32.0	91.0
Government of Tajikistan	3.2	9.0
Total	**35.2**	**100.0**

Source: Asian Development Bank. 2017. *Country Operations Business Plan: Tajikistan, 2018−2020*. Manila.

E. Implementation Arrangements

24. **Project organization structure.** MOHSPP will be the project executing agency. The project administration group (PAG), to be established under MOHSPP, will be the implementing agency. The PAG will undertake procurement and administer contracts. MOHSPP will nominate candidates for the position of PAG manager, who will monitor and guide day-to-day implementation. The PAG manager and key staff will be selected in a competitive procedure and financed by the project under the recurrent cost category. A project steering committee will be set up to provide overall guidance on project implementation. Roles, responsibilities, and draft terms of reference for staff—and consultants to be hired to provide project implementation support to MOHSPP and the PAG—are described in the PAM (footnote 21).

[22] ADB. 2017. *Country Operations Business Plan: Tajikistan, 2017–2019.* Manila.

Table 3: Implementation Arrangements

Aspects	Arrangements		
Implementation period	March 2019 –February 2025		
Estimated completion date	28 February 2025		
Estimated grant closing date	31 August 2025		
Management			
(i) Oversight body	Project steering committee		
(ii) Executing agency	Ministry of Health and Social Protection of the Population of the Republic of Tajikistan		
(iii) Implementing agency	PAG under the Ministry of Health and Social Protection of the Population		
Procurement	OCB - works	3 contracts	$12.714 million
	OCB - goods	6 contracts	$6.964 million
	RFQ	3 contracts	$0.159 million
Consulting services	Individual consultant Recruitment	1,071 person-months national 6 person-months international	$1.326 million $0.155 million
	Quality and cost-based selection	406 person-months	$3.096 million
	Least-cost selection	12 person-months	$0.071 million
	Direct contracting	324 person-months	$3.500 million
	Fixed budget selection	55 person-months	$0.463 million
Retroactive financing and/or advance contracting	Advance contracting: (i) PAG key personnel, (ii) individual consultants, (iii) project implementation support consultant, (iv) design and supervision firm, and (v) UNICEF		
	Retroactive financing: (i) PAG key personnel and (ii) individual consultants.		
Disbursement	The grant proceeds will be disbursed following ADB's *Loan Disbursement Handbook* (2017, as amended from time to time) and detailed arrangements agreed between the government and ADB.		

ADB = Asian Development Bank, OCB = open competitive bidding, PAG = project administration group, RFQ = request for quotation, UNICEF = United Nations Children's Fund.

III. DUE DILIGENCE

A. Technical

25. The civil works packages under Output 2 are technically feasible, utilizing an efficient solution of a centralized diagnostic and treatment platform buildings. Preliminary design reflects environmentally sound heating and cooling solutions, as well as cost-effective waste treatment processes. Outputs 1 and 3 will ensure sustainability of the project through (i) training of health workers through on-the-job training; (ii) establishment of a CME institute for health workers with MOHSPP; (iii) building the capacity of central, regional, and district health and financial administrations; (iv) re-introduction of equipment maintenance specialist at district hospitals within the project area and ensure staffing; and (v) inclusion of operation and maintenance expenditures in annual facility budgets.

B. Economic and Financial

26. **Economic analysis.** An economic analysis was conducted by ADB staff in accordance with relevant ADB guidelines.[23] Two main streams of project benefits are quantifiable. First, the project will lead to cost savings in MCH care for vulnerable households. Second, the project will lead to higher productivity of beneficiaries by helping reduce morbidity and mortality. The resulting base-case economic internal rate of return (EIRR) is 9.1%, indicating that the program is economically viable because its value is above the opportunity cost of investment for social sector projects of 6% (footnote 23). A sensitivity analysis indicates that the EIRR is sensitive to changes in costs and benefits. All the scenarios yield EIRR rates above the 6% return on investment for social sector projects.

27. **Financial analysis.** ADB staff undertook a fiscal impact and sustainability analysis on the government's ability to cover provision of counterpart funds, recurrent and maintenance costs. The analysis confirms that the government has adequate financial resources and will be able to fulfill all its financial obligations under the project. The tax exemption cost is significantly less than 1% of the government's total annual expenditure and total health expenditure.

C. Governance

28. **Financial management.** An assessment of the financial management arrangements for the project concluded that the risk rating is substantial for the following reasons: (i) insufficient financial management capacity of the executing and implementing agencies, (ii) a partially automated payment system, (iii) weak internal audit capacity,(iv) lack of an integrated financial management information system; (v) no external audits, and (vi) lack of experience with ADB's financial management requirements and disbursement procedures. The risk will be mitigated with an action plan that includes: (i) conducting regular training for project staff on financial management and providing consultant support to PAG; (ii) developing a financial manual that will also define internal control measures such as segregation of duties, authorizations, obligations, and reconciliations; (iii) providing technical support to create an internal audit manual and methodology, as well as an internal audit charter to guide PAG activities; (iv) having project financial statements audited by independent auditors based on terms of reference agreed with the ADB; (v) installing of a fully automated accounting system that will generate interim financial reports to be submitted to ADB regularly and on time; and (vi) adopting a project accounting system to ensure quality and reliable accounting and reporting.

29. **Procurement.** An assessment of the procurement arrangements concluded that the procurement risk is *substantial* because of limited capacity for following ADB procedures. The risk will be mitigated by hiring experienced procurement specialists for the PAG. All procurement (including consulting services and advance actions) will be undertaken in full conformity with the ADB Procurement Policy (2017, as amended from time to time) and Procurement Regulations for ADB Borrowers (2017, as amended from time to time) as indicated in the PAM (footnote 21). The procurement plan will be updated at least annually, and proposed changes will require ADB approval. ADB will be responsible for oversight and monitoring, including posting the initial procurement plan and any subsequent changes. Civil works will be procured through open competitive bidding.

30. Executing/implementing agency has been recommended to consider direct contracting with UNICEF related to some activities in Output 1 and 3, subject to ADB review. UNICEF has

[23] ADB. 2017. *Guidelines for the Economic Analysis of Projects.* Manila.

rich experience in maternal and child health and behavior change communication in Tajikistan and most of the output activities in continuous quality improvement, supportive supervision, and behavior change communication strategy are continuation of previous work done by UNICEF.[24] The choice of UNICEF allows for an expeditious contracting and commencement of implementation of soft components of the project and there are financial advantages due to multiplier effect of investments.

31. ADB's Anticorruption Policy (1998, as amended to date) was explained to and discussed with the government and the MOHSPP. The policy requirements and supplementary measures are described in the PAM (footnote 21).

D. Poverty, Social, and Gender

32. The project addresses key poverty and social issues by bringing improved and accessible health services closer to patients. The primary beneficiaries of the project will be the rural population, especially, women of reproductive age, pregnant women, and children who are frequent users of health services. The project will also benefit health workers across the entire health system, but most particularly those working on MCH services in hospitals or at PHC facilities in project districts. The project will assist the poor and vulnerable by better preparing clinical staff to diagnose, treat, counsel, and adhere to MCH referral protocols, and thus better respond to the health concerns of the community. The project will also involve the community in BCC activities by engaging with community leaders, religious leaders, and representatives of women's committees to raise people's awareness of MCH and other health issues and improve access to quality health care services. TRTA prepared a poverty reduction and social strategy that includes measures to manage social impacts and enhance the distribution of benefits from the project.

33. **Gender.** The project is classified as *gender equity* because it directly tackles the problem of poor access to MCH health services. Specifically, it targets a significant increase in the number of women and children who seek health care services, and the timely and quality provision of antenatal, delivery, postnatal, and well-child care and services. It will build or rehabilitate obstetrics and gynecological units in the district hospitals and equip them with the necessary medical equipment, as well as women- and child-friendly facilities such as private examination rooms, sex-segregated toilets, and diaper-changing rooms. The project will also help develop gender-sensitive referral protocols and ensure continuous training of professional MCH staff such as family doctors, nurses, and midwives. Finally, the project will address the sociocultural attitudes that keep the population from seeking timely MCH services by launching a BCC campaign that targets women of reproductive age, husbands, and mothers-in-law, as well as middle and high school students. The project has a gender action plan that outlines the gender equality interventions that will improve women's access to quality health services.

E. Safeguards

34. In compliance with ADB's Safeguard Policy Statement (2009), the project's safeguard categories are as follows.[25]

35. **Environment (category B).** The project is classified B for environment under ADB's Safeguard Policy Statement 2009 (SPS 2009). In accordance with SPS 2009 an initial environmental examination (IEE) report, including an environmental management plan (EMP),

[24] Paragraph 2.17, provision of ADB Procurement Strategy (2017, as amended from time to time).
[25] ADB. Safeguard Categories.

has been prepared, covering all facilities to be rehabilitated under this project. Potential negative environmental impacts are largely related to construction activities under output 2. The main identified impacts during construction or reconstruction are dust, solid waste, and occupational and community health risks, such as those arising from removal, handling, and disposal of old asbestos sheeting. Dust and/or solid waste impacts will also arise from small-scale outdoor construction activities—such as building septic tanks and repairing water supply and canalization systems—and when replacing old equipment. Impacts during operation are expected from the storage and disposal of medical waste. The EMP defines mitigation measures and monitoring requirements and will be included as an appendix in all bidding and contract documents. A site-specific EMP will be prepared by the contractor before construction and approved by the PAG. The institutional capacity of the borrower to manage environmental risks and operational tasks in connection with health care waste is limited. To raise awareness and develop the capacity of MOHSPP, hospitals, health centers, and district administrations, project activities to build environmental management capacity will include training programs at hospitals and health centers that specifically deal with hospital and domestic waste management. The IEE provides guidance for contractors on preparing a waste management plan. The cost for implementing the EMP will be borne by the project, while the costs of mitigating measures will be included in the construction contracts, and the cost for environmental monitoring and training of the PAG will be included in the consulting services of the construction supervision consultants. A full-time environment specialist in the PAG will oversee and monitor the implementation of the EMP and site-specific plans.

36. **Involuntary resettlement (category C).** Social safeguards due diligence confirmed that the project activities will neither require land acquisition nor resettlement. Construction or rehabilitation of district hospitals and DHCs will take place within the existing land. If any changes or additional land requirements or involuntary resettlement impacts are identified during the project implementation stage, a resettlement plan will be prepared in accordance with the ADB SPS (2009) and national requirements. The resettlement plan needs to be fully implemented before any works start at the impact sites. A resettlement framework is not required as under the involuntary resettlement category C.

37. **Indigenous peoples (category C).** No indigenous peoples, as defined in ADB's Safeguard Policy Statement, live in the project area, so the project is classified as category C for indigenous peoples impacts.

38. **Public disclosure.** The IEE and EMP will be endorsed and disclosed publicly once the government has endorsed the project and before approval by the ADB Board of Directors. Information about the project including general project information, contact details, project progress, procurement, and audited financial statements of the project, will be publicly disclosed.

F. Summary of Risk Assessment and Risk Management Plan

39. Significant risks and mitigating measures are summarized in Table 4 and described in detail in the risk assessment and risk management plan.

Table 4: Summary of Risks and Mitigating Measures

Risks	Mitigation Measures
Assumptions and proposed actions of the masterplan for the development of MCH services in the project districts will not be implemented	Tri-partite agreement between MOHSPP, MOF and local governments on masterplan adoption will be signed as part of project covenants.
Frequent turnover of trained staff	Intensify supportive supervision to fill the knowledge gap through on-the-job-training and mentoring to new staff.
Delays in setting-up the PAG and launching tenders for consulting services may delay project implementation.	MOHSPP has started taking steps to establish the PAG; preparation for consultant engagement will be supported by TA.
Limited procurement and financial risk management capacity	The PAG will be established to support MOHSPP in financial and procurement management. Training will be provided to MOHSPP and PAG staff.
Financial resources will not be sufficient to maintain improved conditions (infrastructure and equipment, qualified staff) for medical services in the target hospitals	The use of energy saving technologies for new buildings will help in limiting utilities and maintenance expenditures. The tri-partite agreement contains provision for budget retention despite cuts in the number of beds which can be allocated to the maintenance fund.

MCH = maternal and child health, MOF = Ministry of Finance, MOHSPP = Ministry of Health and Social Protection of the Population of the Republic of Tajikistan, PAG= project administration group, TA= Technical assistance
Source: Asian Development Bank.

IV. ASSURANCES

40. The government and MOHSPP have assured ADB that the implementation of the project shall conform to all applicable ADB policies, including those concerning anticorruption measures, safeguards, gender, procurement, consulting services, and disbursement as described in detail in the PAM and grant documents.

41. The government and MOHSPP have agreed with ADB on certain covenants and conditions for the project, which are set forth in the draft grant agreement. Signing of a tri-partite agreement between MOHSSP, Ministry of Finance and the district governments of the project districts on the adoption of the masterplan for the development of MCH services is a condition to disbursement.

V. RECOMMENDATION

42. I am satisfied that the proposed grant would comply with the Articles of Agreement of the Asian Development Bank (ADB) and recommend that the Board approve the grant not exceeding $32,000,000 to the Republic of Tajikistan from ADB's Special Funds resources (Asian Development Fund) for the Maternal and Child Health Integrated Care Project, on terms and conditions that are substantially in accordance with those set forth in the draft grant agreement presented to the Board.

Takehiko Nakao
President

2 November 2018

DESIGN AND MONITORING FRAMEWORK

Impact the Project is Aligned with Health status and well-being of mothers and children in the project districts improved (Sustainable Development Goal 3)[a]			
Results Chain	**Performance Indicators with Targets and Baselines**	**Data Sources and Reporting Mechanisms**	**Risks**
Outcome Coverage of women and children with quality MCH services in the project districts improved	By 2026: 1. At least 10% increase in institutional/hospital deliveries in Rasht and Sh. Shohin, and 3% in Fayzobod (2016 baseline: Rasht 69%, Shamsiddin Shohin 62%, and Fayzobod 93%). 2. At least 50% of deliveries in project hospitals with referral slips from primary health care providers (2017 baseline: 0)[b] 3. Share of medically justified hospitalizations[c] among children aged 0-5 years increased by 10% (2017 baseline: 0)[b]	1. MOHSPP, district health information system (annual) 2.–3. Baseline and end-line surveys, MOHSPP	Economic downturn reduces households' budget for health
Outputs 1. Integrated delivery of quality maternal and child care services in project districts improved	By 2025: 1a. At least 50% of MCH health workers trained on gender sensitive referral protocols (2017 baseline: 0)[b] 1b. Health budgets for project districts retained and case-based payment system piloted in at least two project hospitals (2017 baseline: 0) [b]	1a.–3a. Project report, MOHSPP (annual)	
2. Infrastructure and equipment for MCH services in project districts rationalized and improved	By 2025: 2a. At least one district health center and one central district hospital per project district upgraded (2017 baseline: 0)[b] 2b. Equipment management system established (2017 baseline: 0)		Exchange rate fluctuations beyond project projections may raise construction costs significantly
3. Knowledge of MCH and health seeking behaviors in project districts improved	By 2025: 3a. District specific BCC strategy on MCH, targeting both women and men, developed and implemented in project catchment areas (2017 baseline: 0)[b] 3b. At least 85% of pregnant women received MCH booklet (2017 baseline: 0) [b]	3b. Baseline, midline, and end-line surveys on knowledge,	Behavior change is a complex outcome and may not materialize as expected despite the many project activities in this area.

Results Chain	Performance Indicators with Targets and Baselines	Data Sources and Reporting Mechanisms	Risks
		attitudes and practices, MOHSPP	

Key Activities with Milestones:

1. Integrated delivery of quality maternal and child care services in project districts improved

1.1 Start recruiting a firm for integrated delivery of MCH and BCC by Q4 2018
1.2 Develop district-specific health workforce training plan by Q4 2019
1.3 The government approves health workforce planning and deployment strategy by Q4 2021
1.4 Train health personnel in project districts on using referral pathways by Q4 2022
1.5 Develop operational manual for continuous quality improvement by Q4 2020
1.6 Train health facility management and staff on how to apply continuous quality improvement approaches by Q4 2021
1.7 Develop and approve design, methods, processes and tools of a supportive supervision system by Q3 2020
1.8 Develop an operational manual for the supportive supervision system by Q4 2020
1.9 Initiate supportive supervision in project districts by Q1 2021
1.10 Develop infection control policy, facility specific plans and clinical practice guidelines by Q2 2022
1.11 Develop national medical waste management policy by Q2 2022
1.12 Develop and approve waste management operational manual and standard operating procedures by Q4 2022
1.13 Develop and approve regulatory framework for piloting case-based payment system by Q3 2020
1.14 Develop case-based and referral information system by Q4 2020

2. Infrastructure and equipment for MCH services in project districts rationalized and improved.

2.1 Issue the request for proposal of design and supervision consultants by Q4 2018
2.2 Invite bids for works by Q2 2020
2.3 Evaluate proposals and award contracts by Q3 and Q4 2020
2.4 Start construction and rehabilitation of selected health facilities by Q1 2021
2.5 Invite bids for furniture and equipment by Q4 2022
2.6 Evaluate and award contracts for furniture and equipment by Q2 2022
2.7 Deliver and install furniture and equipment by Q2 2023
2.8 Complete rehabilitation and construction works by Q3 2023
2.9 Conduct final acceptance and issue final payment for works by Q3 2024 and for equipment by Q2 2025

3. Knowledge of MCH and health seeking behaviors in project districts improved

3.1 Start of recruiting a firm for integrated delivery of MCH and BCC by Q4 2018
3.2 Complete baseline assessment of population knowledge, attitude and practice in project pilot districts by Q3 2020
3.3 Develop district specific BCC strategy and implementation plan by Q1 2019
3.4 Print BCC materials by Q3 2020
3.5 Develop communication strategy and plan for effective stakeholder communication by Q2 2019
3.6 Start implementation of BCC strategy by Q3 2020
3.7 Implement communication strategy by Q1 2020
3.8 Implement community small grants program by Q 3 2020

Project Management Activities

Start recruiting project administration group staff (17 staff) in Q4 2018
Start recruiting financial management consultant and an integrated care consultant (individuals) in Q4 2018
Start tender for office furniture and equipment for the PAG and vehicles (2 units) in Q4 2018

Issue request for proposal of project implementation support firm by Q1 2019
Inputs Asian Development Bank: $32 million (Asian Development Fund grant) Government of Tajikistan: $3.2 million
Assumptions for Partner Financing: German development cooperation through KfW, case-based payment system pilot and national medical equipment maintenance concept implemented (€9 million)

BCC = behavior change communication; MCH = maternal and child health; MOHSPP = Ministry of Health and Social Protection of the Population of the Republic of Tajikistan; Q = quarter.

[a] Government of Tajikistan, 2017. *National Development Strategy.* Dushanbe.

[b] The indicated baseline will be updated once baseline survey data are collected.

[c] "Medically justified" hospitalization means that patients have a condition for which treatment can only be provided in a hospital setting. Numerator is derived through criteria-based audit of medical records, which will be obtained from baseline and end-line project surveys. Denominator will be the total number of pediatric hospitalizations in a given facility during the reporting period that matches the baseline and end-line surveys.

Source: Asian Development Bank.

LIST OF LINKED DOCUMENTS

http://www.adb.org/Documents/RRPs/?id=51010-002-2

1. Grant Agreement
2. Sector Assessment (Summary): Health
3. Project Administration Manual
4. Contribution to the ADB Results Framework
5. Development Coordination
6. Economic and Financial Analysis
7. Country Economic Indicators
8. Summary Poverty Reduction and Social Strategy
9. Risk Assessment and Risk Management Plan
10. Gender Action Plan
11. Initial Environmental Examination

Supplementary Documents

12. Case-Based Payment System Pilot
13. Criteria for Selection of Project Districts