Report No: PAD3811

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT
ON A
PROPOSED INTERNATIONAL ASSOCIATION DEVELOPMENT GRANT

IN THE AMOUNT OF SDR 8.3 MILLION
(US$ 11.3 MILLION EQUIVALENT)
{IN CRISIS RESPONSE WINDOW RESOURCES}

TO THE

REPUBLIC OF TAJIKISTAN

FOR A

TAJIKISTAN EMERGENCY COVID-19 PROJECT

UNDER THE
COVID-19 STRATEGIC PREPAREDNESS AND RESPONSE PROGRAM (SPRP)

USING THE MULTIPHASE PROGRAMMATIC APPROACH (MPA)
WITH AN IBRD AND IDA FINANCING ENVELOPE OF
US$1.3 BILLION IDA AND $2.3 BILLION EQUIVALENT

APPROVED BY THE BOARD ON APRIL 2, 2020

Health, Nutrition & Population Global Practice
Europe And Central Asia Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective {March 17, 2020})

Currency Unit =	Tajikistan Somoni (TJS)
TJS9.7365 =	US$1
US$ =	SDR 1

FISCAL YEAR
January 1 - December 31

Regional Vice President:	Cyril E Muller
Country Director:	Lilia Burunciuc
Regional Director:	Fadia M. Saadah
Practice Manager:	Tania Dmytraczenko
Task Team Leader(s):	Kate Mandeville, Baktybek Zhumadil

ABBREVIATIONS AND ACRONYMS

ADB	Asian Development Bank
COVID-19	Coronavirus Disease 2019
CPF	Country Partnership Framework
DSESEEMC	Division of Sanitary and Epidemiological Safety, Emergencies and Emergency Medical Care
DSPP	Division for Social Protection of Population
ERP	Emergency Response Plan
EVD-WA	West African Ebola Virus Disease
GDP	Gross Domestic Product
GNI	Gross National Income
HSIP	Health Service Improvement Project
ICU	Intensive Care Unit
IEG	Independent Evaluation Group
IMF	International Monetary Fund
IPC	Infection prevention control
MOHSP	Ministry of Health and Social Protection
MSF	Médecins Sans Frontières
PASHA	Pakistan Software Houses Association
PIM	Project Implementation Manual
PIU	Project Implementation Unit
POM	Project Operational Manual
PPE	Personal Protective Equipment
RCST	Red Crescent Society of Tajikistan
SASP	State Agency for Social Protection
SCD	Systematic Country Diagnostic
SDC	Swiss Agency for Development Cooperation
SSNSP	Tajikistan Social Safety Nets Strengthening Project
TA	Technical assistance
TSA	Targeted Social Assistance
TSG	Technical Support Group
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization

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DATASHEET

BASIC INFORMATION

Country(ies)	Project Name	
Tajikistan	Tajikistan Emergency COVID-19 Project	
Project ID	**Financing Instrument**	**Environmental and Social Risk Classification**
P173765	Investment Project Financing	Substantial

Financing & Implementation Modalities

[✓] Multiphase Programmatic Approach (MPA)	[ ] Contingent Emergency Response Component (CERC)
[ ] Series of Projects (SOP)	[ ] Fragile State(s)
[ ] Disbursement-linked Indicators (DLIs)	[ ] Small State(s)
[ ] Financial Intermediaries (FI)	[ ] Fragile within a non-fragile Country
[ ] Project-Based Guarantee	[ ] Conflict
[ ] Deferred Drawdown	[✓] Responding to Natural or Man-made Disaster
[ ] Alternate Procurement Arrangements (APA)	

Expected Project Approval Date	Expected Project Closing Date	Expected Program Closing Date
26-Mar-2020	01-Dec-2021	31-Dec-2025

Bank/IFC Collaboration

No

MPA Program Development Objective

The Program Development Objective (PDO) is to prevent, detect and respond to the threat posed by COVID-19 and strengthen national systems for public health preparedness.

MPA Financing Data (US$, Millions)

MPA Program Financing Envelope	11.30

Proposed Project Development Objective(s)

Project Development Objective (PDO) is to prepare and respond to the COVID-19 pandemic in the Republic of Tajikistan.

Components

Component Name	Cost (US$, millions)
Component 1. Strengthening intensive care capacity	6.30
Component 2. Multi-sectoral response planning and community preparedness	1.00
Component 3. Temporary social assistance for vulnerable households	3.00
Component 4. Project Implementation and Monitoring	1.00

Organizations

Borrower:	Republic of Tajikistan
Implementing Agency:	Ministry of Health and Social Protection State Agency for Social Protection

MPA FINANCING DETAILS (US$, Millions)

MPA Program Financing Envelope:	11.30
of which Bank Financing (IBRD):	0.00
of which Bank Financing (IDA):	11.30
of which other financing sources:	0.00

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	11.30
Total Financing	11.30
of which IBRD/IDA	11.30
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	11.30
IDA Grant	11.30

IDA Resources (in US$, Millions)

	Credit Amount	Grant Amount	Guarantee Amount	Total Amount
Tajikistan	0.00	11.30	0.00	11.30
Crisis Response Window (CRW)	0.00	11.30	0.00	11.30
Total	**0.00**	**11.30**	**0.00**	**11.30**

Expected Disbursements (in US$, Millions)

WB Fiscal Year	2020	2021	2022
Annual	10.00	0.80	0.50
Cumulative	10.00	10.80	11.30

INSTITUTIONAL DATA

Practice Area (Lead)
Health, Nutrition & Population

Contributing Practice Areas
Social Protection & Jobs

Climate Change and Disaster Screening
This operation has not been screened for short and long-term climate change and disaster risks

Explanation
Not applicable

SYSTEMATIC OPERATIONS RISK-RATING TOOL (SORT)

Risk Category	Rating

1. Political and Governance	Substantial
2. Macroeconomic	High
3. Sector Strategies and Policies	Substantial
4. Technical Design of Project or Program	Moderate
5. Institutional Capacity for Implementation and Sustainability	Moderate
6. Fiduciary	Substantial
7. Environment and Social	Substantial
8. Stakeholders	Moderate
9. Other	
10. Overall	Substantial
Overall MPA Program Risk	Substantial

COMPLIANCE

Policy

Does the project depart from the CPF in content or in other significant respects?

[ ] Yes [✓] No

Does the project require any waivers of Bank policies?

[✓] Yes [ ] No

Have these been approved by Bank management?

[✓] Yes [ ] No

Is approval for any policy waiver sought from the Board?

[ ] Yes [✓] No

Environmental and Social Standards Relevance Given its Context at the Time of Appraisal

E & S Standards	Relevance
Assessment and Management of Environmental and Social Risks and Impacts	Relevant
Stakeholder Engagement and Information Disclosure	Relevant
Labor and Working Conditions	Relevant
Resource Efficiency and Pollution Prevention and Management	Relevant
Community Health and Safety	Relevant
Land Acquisition, Restrictions on Land Use and Involuntary Resettlement	Not Currently Relevant
Biodiversity Conservation and Sustainable Management of Living Natural Resources	Not Currently Relevant
Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities	Not Currently Relevant
Cultural Heritage	Not Currently Relevant
Financial Intermediaries	Not Currently Relevant

NOTE: For further information regarding the World Bank's due diligence assessment of the Project's potential environmental and social risks and impacts, please refer to the Project's Appraisal Environmental and Social Review Summary (ESRS).

Legal Covenants

Sections and Description

The Recipient shall by no later than one (1) month after the Effective Date, prepare and adopt a Project operations manual.

Sections and Description

The Recipient shall prepare and adopt, no later than one (1) month from the Effective Date, an ESMF satisfactory to the Association.

Sections and Description

The Recipient shall by no later than one (1) month after the Effective Date, recruit a project officer, finance officer, a procurement officer, and an environmental and social safeguards officer for the PCG.

Sections and Description
The Recipient shall maintain, throughout the Project implementation, a Standing Headquarters on Outbreak Prevention and Containment chaired by the Prime Minister with a steering role for the overall national response, and for the Project interventions specifically, with role, composition, and functions described in the POM.

Conditions

Type	Description
Disbursement	Under Category (2) until the Recipient has adopted a decree mandating nation-wide rollout of the Targeted Social Assistance, with parameters satisfactory and administrative costs satisfactory to the Association.
Type	Description
Effectiveness	The MoF, MoHSP, and SASP have concluded a Project Implementation Agreement satisfactory to the Association.

I. PROGRAM CONTEXT

1. This Project Appraisal Document (PAD) describes the emergency response to the Republic of Tajikistan under the COVID-19 Strategic Preparedness And Response Program (SPRP) using the Multiphase Programmatic Approach (MPA), approved by the World Bank's Board of Executive Directors on April 2, 2020 (Report No. PCBASIC0219761) with an overall Program financing envelope of International Development Association (IDA) US$1.3 billion and of International Bank for Reconstruction and Development (IBRD) US$2.7 billion.[1]

A. MPA Program Context

2. **An outbreak of the coronavirus disease (COVID-19) caused by the 2019 novel coronavirus (SARS-CoV-2) has been spreading rapidly across the world since December 2019, following the diagnosis of the initial cases in Wuhan, Hubei Province, China**. Since the beginning of March 2020, the number of cases outside China has increased thirteenfold and the number of affected countries has tripled. On March 11, 2020, the World Health Organization (WHO) declared a global pandemic as the coronavirus rapidly spreads across the world. Figure 1 provides details about the global spread of COVID-19. As of March 25, 2020, the outbreak has resulted in an estimated 414,686 cases and 18,589 deaths in 196 countries.

3. **COVID-19 is one of several emerging infectious diseases (EID) outbreaks in recent decades that have emerged from animals in contact with humans, resulting in major outbreaks with significant public health and economic impacts.** The last moderately severe influenza pandemics were in 1957 and 1968; each killed more than a million people around the world. Although countries are now far more prepared than in the past, the world is also far more interconnected, and many more people today have behavior risk factors such as tobacco use[2] and pre-existing chronic health problems that make viral respiratory infections particularly dangerous[3]. With COVID-19, scientists are still trying to understand the full picture of the disease symptoms and severity. Reported symptoms in patients have varied from mild to severe, and can include fever, cough and shortness of breath. In general, studies of hospitalized patients have found that about 83% to 98% of patients develop a fever, 76% to 82% develop a dry cough and 11% to 44% develop fatigue or muscle aches[4]. Other symptoms, including headache, sore throat, abdominal pain, and diarrhea, have been reported, but are less common. While 3.7% of the people worldwide confirmed as having been infected have died, WHO has been careful not to describe that as a mortality rate or death rate. This is because in an unfolding epidemic it can be misleading to look simply at the estimate of deaths divided by cases so far. Hence, given that the actual prevalence of COVID-19 infection remains unknown in most countries, it poses unparalleled challenges with respect to global containment and mitigation. These issues reinforce the need to strengthen the response to COVID-19 across all IDA/IBRD countries to minimize the global risk and impact posed by this disease.

4. This project is prepared under the global framework of the World Bank COVID-19 Response financed under the Fast Track COVID-19 Facility (FCTF).

[1] Global MPA PAD Report No: PCBASIC0219761
[2] Marquez, PV. 2020. "Does Tobacco Smoking Increases the Risk of Coronavirus Disease (Covid-19) Severity? The Case of China." *http://www.pvmarquez.com/Covid-19*
[3] Fauci, AS, Lane, C, and Redfield, RR. 2020. "Covid-19 — Navigating the Uncharted." New Eng J of Medicine, DOI: 10.1056/NEJMe2002387
[4] Del Rio, C. and Malani, PN. 2020. "COVID-19—New Insights on a Rapidly Changing Epidemic." JAMA, doi:10.1001/jama.2020.3072

B. Updated MPA Program Framework

5. Table 1 shows the proposed project as part of the overall MPA Program framework.

Table 1. MPA Program Framework

Phase #	Project ID	Sequential or Simultaneous	Phase's Proposed DO*	IPF, DPF or PforR	Estimated IBRD Amount ($ million)	Estimated IDA Amount ($ million)	Estimated Other Amount ($ million)	Estimated Approval Date	Estimated Environmental & Social Risk Rating
1	Tajikistan Emergency COVID-19 Project (P173765)	Simultaneous	To prepare and respond to the COVID-19 pandemic in the Republic of Tajikistan	IPF	0.00	$11.3	-	April 2, 2020	Substantial
Total			**Board Approved Financing Envelope**		**$2,700.00**	**$1,300.00**			

C. Learning Agenda

6. The project under the MPA Program will support adaptive learning throughout the implementation, as well as from international organizations including WHO, IMF, CDC, UNICEF, and others. The global MPA aims the following:

- Forecasting: modeling the progression of the pandemic, both in terms of new cases and deaths, as well as the economic impact of disease outbreaks under different scenarios.
- Technical: Cost and effectiveness assessments of prevention and preparedness activities; research may be financed for the re-purposing of existing anti-viral drugs and development and testing of new antiviral drugs and vaccines.
- Supply chain approaches: Assessments may be financed on options for timely distribution of medicines and other medical supplies.
- Social behaviors: Assessments on the compliance and impact of social distancing measures under different contexts.

7. **The Project aims to support a robust learning agenda targeted to Project activities**. Both current and new survey tools will be utilized to assess the impact of Project activities (see Project description below). The Listening to Tajikistan survey is a household panel survey that continuously monitors life satisfaction in Tajikistan, providing information that can help to quantify the severity of shocks, and their importance for wellbeing. Mobile Engage[5] is a geo-targeted text message-based two-way system to communicate with people who are otherwise challenging to contact. The Listening to Tajikistan survey may be used to investigate the distributional impact of cash transfers to vulnerable households under the Project. Both Listening to Tajikistan and Mobile Engage will be used to assess the effectiveness of communications and outreach activities on behavior change, including on nutrition. Finally, if feasible, data on the utilization of intensive care units supported by the Project will be gathered, to undertake a cost-effectiveness analysis and equity audit of expanded intensive care capacity.

[5] The Mobile Engage system is currently under development by the World Bank with support from the Korea Trust Fund for Economic and Peace-Building Transitions. It is planned that the platform will be hosted by the Ministry of Health and Social Protection of Tajikistan after initial development.

II. CONTEXT AND RELEVANCE

8. **Over the coming months, the outbreak has the potential to cause greater loss of life, significant disruptions in global supply chains, lower commodity prices, and economic losses in both developed and developing countries.** The COVID-19 outbreak is affecting supply chains and disrupting manufacturing operations around the world. Economic activity has fallen in the past two months, especially in China, and is expected to remain depressed for months. The outbreak is taking place at a time when global economic activity is facing uncertainty and governments have limited policy space to act. The length and severity of impacts of the COVID-19 outbreak will depend on the projected length and location(s) of the outbreak, as well as on whether there are is a concerted, fast track response to support developing countries, where health systems are often weaker. With proactive containment measures, the loss of life and economic impact of the outbreak could be arrested. It is hence critical for the international community to work together on the underlying factors that are enabling the outbreak, supporting policy responses, and strengthening response capacity in developing countries – where health systems are weakest, and hence populations most vulnerable.

9. **The World Bank Group (WB) has created a dedicated, Fast Track COVID-19 Facility to help developing countries address the emergency response to and impacts of the outbreak.** The WB's Fast Track COVID-19 Fast Facility will be a globally-coordinated, country-based response to support health systems and emergency response capacity in developing countries, focused largely on health system response, complemented by support for economic and social disruption.

10. **Globally, the WB's support includes financing and technical assistance (TA).** In terms of TA, to date the WB has contributed to the World Health Organization (WHO)-led development of a Strategic Preparedness and Response Plan outlining the public health measures for all countries to prepare for, and respond to, 2019-nCoV. The strategic objectives of the Plan are to: (a) limit human-to-human transmission; (b) identify, isolate, and care for patients early; (c) identify and reduce transmission from the animal source; (d) address crucial unknowns regarding clinical severity, extent of transmission and infection, treatment options, and accelerate the development of diagnostics, therapeutics, and vaccines; (e) communicate critical risk and event information to all communities, and counter misinformation; and (f) minimize social and economic impact through multi-sectoral partnerships. To support these, the Plan relies on three pillars:

(a) rapidly establishing international coordination to deliver strategic, technical, and operational support through existing mechanisms and partnerships;
(b) scaling up country preparedness and response operations, and
(c) accelerating priority research and innovation.

A. Country Context

11. **Tajikistan is a low-income IDA country with a large proportion of the population vulnerable to poverty and shocks, despite notable accomplishments in poverty reduction over the past 20 years.** Tajikistan is a land-locked country, which borders China, and 93 percent of its terrain is mountainous. It has a population of 9.1 million[6]. From 2000-2015 the country had an average economic growth rate of 7.7 percent annually, yet by 2018 still had the lowest GDP per capita in the Europe and Central Asia (ECA) region at US$3061 (in 2011 PPP terms).

[6] Official data of the State Agency on Statistics under the Government of Tajikistan (GoT), 2018.

Nonetheless, the country has achieved sustained progress in reducing poverty in the national official poverty rate, from more than 37 percent in 2013 to about 27 percent in 2019. Remittance inflows are a powerful driver of poverty reduction in Tajikistan (in total equivalent to 29 percent of GDP in 2018), and exports are dominated by commodities, especially cotton and aluminum. About 70 percent of the population lives in rural areas according to official projections, and the agricultural sector is by far the largest employer in the country. Rural and remote areas are significantly poorer than urban settings on average, and face highly volatile incomes compounded by strong seasonality – the national poverty rate rises be as much as 8 percentage points during the winter and spring months.

12. **The CPF and SCD also note the country's social vulnerabilities and fragility risks, and these are compounded by the country's geography.** Fragility risks include: the legacy of the 1992-97 civil war; persistent poverty pockets in lagging regions; income insecurity; under and unemployment and security risks emanating from the 1,400-kilometer border with Afghanistan, where there is currently an outbreak of COVID-19. In addition, service delivery to most Tajiks is challenged by Tajikistan's country geography. Tajikistan is one of the most vulnerable countries in the region to impacts from climate change, exacerbated by its limited capacity to respond to natural hazards. From 1992 to 2016, disasters in Tajikistan are estimated to have caused economic losses in excess of US$1.8 billion, affecting almost 7 million people.

13. **Tajikistan's economic ties to China, where the outbreak began, make it particularly vulnerable and both WB and IMF projections point towards a steep reduction in GDP growth in 2020.** In 2019, China was Tajikistan's largest trading partner accounting for 4.7% of the export market and 18.1% of its import market. Further, oil prices fell in the first quarter of 2020 to lows not seen since the Great Recession, greatly reducing expected remittance inflows from Russia and limiting the growth outlook for Tajikistan's immediate neighbors. This combination of factors stands to cause a decline in consumption expenditure and imports, lowering tariff and VAT revenue and leading to a deterioration in fiscal sustainability. Aluminum, Tajikistan's primary export commodity at 17 percent of exports, hit a 40-month low of $1,665 per ton in January. New foreign direct investment is also expected to decline.

14. **Remittances from Russia to Tajikistan are expected to sharply decline due to expected travel restrictions, the rapid ruble depreciation in Q1 of 2020, and collapsing oil prices.** Tajik migrants living in Russia are the source of more than 90 percent of remittance income in Tajikistan, and the rapidly deteriorating economic prospects in Russia linked to falling oil prices, fears of the Covid-19 outbreak spreading, and exchange rate volatility are severe risks to economic stability in Tajikistan. Changes in the flow of remittances are expected to have a substantial impact on food security, particularly for vulnerable populations. In 2019, more than 10 percent of households reported an inability to buy enough food. More than half of households receiving remittances report using remittance income primarily to support household consumption of food and other basic necessities. Moreover, the country struggles with elevated rates of stunting. Finally, as remittances are highly targeted to the poorest regions and districts of the country, declining income from remittances and the absence of a quick recovery will lead to rising incidence and depth of poverty.

15. **Higher inflation and potential labor market impacts are expected to have knock-on effects on vulnerable households and have the potential to increase the prevalence and depth of poverty.** Falling remittances, the expected decline in Chinese imports (many of which are intermediate inputs), and a planned electricity tariff increase of 15 percent this year will place upward pressure on prices and reduce domestic output in comparison to expectations. Domestic business reliant on the supply of external raw materials will also face supply constraints. Approximately 300 Chinese-Tajik joint ventures are operational in Tajikistan and it is expected that they too will

face disruptions on the flow of goods and people. Although the upward price movement in Tajikistan is likely to first be seen largely in non-food commodities, behavioral responses in the event of the outbreak spreading, and further supply constraints may lead to food price increases.

B. Sectoral and Institutional Context

16. **Tajikistan's health system faces long-standing challenges, exacerbating the immediate vulnerability to a COVID-19 pandemic.** The health system is in a period of reform and transition since independence from the former Soviet Union, but progress has been slow. Tajikistan's health care system is tax-financed, with the government being the primary purchaser of health services and little to no risk pooling. Government spending on health as a share of general government spending is low: at around 7 percent, equating to US$17 per capita, with out-of-pocket spending accounting for two-thirds (64 percent) of combined health expenditure. In 2007, 11 percent of households reported spending at least 10 percent of their income on health, markedly higher than other countries in the region. Fiscal space for health remains constrained due to slowing growth and priority given to infrastructure projects in the government budget. Patterns of public health spending – with the bulk of spending on salaries and inpatient care – suggest that there is considerable scope for improvements in the efficiency of spending. There are marked inequities in the health system, evident in the financing and distribution of services and resources. Quality of care is another major concern, which is affected by the lack of investments in health facilities and technologies; an insufficient budget for and financial protection on pharmaceuticals; poorly trained health care workers, especially for pandemic response; and, a need for more specific protocols on pandemic response. This weak health system performance led the WHO to assess Tajikistan's operational readiness for preventing, detecting and responding to a public health emergency as 2 out of 5, among the lowest in the region, and highlights the country's vulnerability to the COVID-19 pandemic.

17. **Recognizing these challenges, the Government of Tajikistan has begun to mobilize a pandemic preparedness response; at the time of project design the Emergency Response Plan (ERP) was in development so appropriateness of activities has been validated through discussion with MOSHP and WHO.** A Standing Headquarters on Outbreak Prevention and Containment (in Tajik the Republican Headquarters for strengthening anti-epidemic measures to prevent transmission and emergence of new COVID-19 cases in the Republic of Tajikistan, here referred to as the Standing Headquarters) was established in February 2020, and has been recently reinforced through an order issued on 18 March 2020, which also elevated the Chairmanship to the level of the Prime Minister. The National Public Health Laboratory has been designated as a reference laboratory for COVID-19 testing and is equipped with adequate diagnostic equipment and staffed by limited WHO-trained technicians (as of March 15, 2020, only 2 lab technicians are trained to perform the COVID-19 diagnostic test). To date, 4,000 test kits have been received from the Russian Federation and the WHO, and, as of March 20, 2020, 3,800 of these had been used. The Government has prepared and assigned 14 facilities (healthcare facilities and a sanatorium) to host quarantined and suspected cases; it also has plans to draw on the facilities, staff and funding of other ministries for use in quarantine, if required, under the leadership of the Ministry of Health and Social Protection (MOHSP). Finally, with the support of the WHO, the MOHSP has established a working group for the development of the COVID-19 Emergency Response Plan (ERP). This plan is due to be finalized soon by national authorities, and overall financing needs are expected to be substantial and in excess of the available WB financing envelope. As the plan was not available at the time of project design, the project has been designed with the best information available and validated through consultation with WHO and MOHSP. For example, the project design does not focus on general screening in all health facilities as protocol training and screening are more likely to be funded and implemented by other development partners.

18. **The WB undertook a rapid gap analysis of emergency response and preparedness, in dialogue with major stakeholders.** During a rapid response preparation mission, the WB held discussions with Government counterparts and development partners to understand challenges in current capacity, resources and clinical care settings. At present, national bodies are severely stretched in terms of coordination, leadership, and communication on the emergency response efforts. The extremely limited number of test kits means that use of these tests is highly prioritized, with likely under-detection of cases (as of March 15, 2020, no case had yet been detected in Tajikistan). Given the lack of resources for a case detection and contact tracing approach, the Government has adopted, at ports of entry only, a mandatory quarantine approach for those with a positive travel history. In the event of an outbreak, it is expected that the Tajik health system could face a surge in demand for medical services of up to 300 percent. At present, intensive care unit (ICU) capacity to treat the most severally ill patients is estimated to be 600 beds (defined as beds appropriately staffed and with functioning ventilators). While there are existing social assistance programs that could be built on, no new social safety net programs have been announced to date.

19. **Multiple donors are committed to supporting the Government's COVID-19 response, and the project activities have been selected in discussion with partners to ensure coordination and avoid duplication.** Between March 10 and 12, 2020, WHO convened a 3-day workshop to develop a health sector operational plan to meet the expected demands in the event of a COVID-19 outbreak. As of now, several donors have donated equipment and items, which were readily available within existing stocks in Tajikistan; this includes: The Aga Khan Health Services (AKHS), Médecins Sans Frontières (MSF), Red Crescent Society of Tajikistan (RCST), the United Nations Children's Fund (UNICEF), the United States Agency for International Development (USAID), and WHO. The WHO continues to provide interim guidelines and recommendations and has provided over 70,000 copies of risk communication materials for health workers and the public. Other development partners involved include the Asian Development Bank, KfW, the Japan International Cooperation Agency, MSF, the Swiss Agency for Development Cooperation (SDC), the United Nations Office for Project Services, and USAID. These partners are involved in a range of activities focused on case detection and prevention, including the procurement and delivery of personal protective equipment, strengthening infection prevention and control, improving laboratory capability, surveillance, risk communication, and community engagement (see Annex 1). Drawing on IEG guidance, the WB and MOSHP will continue to maintain a dialogue with other development partners, to mitigate the risk of quality challenges arising from a rapid preparation.

20. **The proposed activities seek to balance financing immediate emergency response needs and longer-term health system strengthening.** In the event of an outbreak in Tajikistan, surge capacity of ICUs will be needed. Modelling undertaken by the team for Tajikistan based on other countries' experiences shows that patients requiring intensive care will be considerably more (by the magnitude of thousands) than current supply under even low rates of infection (Figure 1). In Italy, which has 5,200 ICU beds (86 per 100,000 against roughly 65 per 100,000 in Tajikistan), 1,028 ICU beds were already devoted to patients with SARS-CoV-2 infection as of March 11, 2020. This has already overwhelmed the ICU system in northern Italy, due to high pre-existing bed occupancy rates as a result of the concentration of COVID-19 patients in northern Italy, and the challenges of transporting COVID-19 patients to other parts of the country. Should an outbreak not materialize in Tajikistan, these investments can be repurposed for ICU capacity for pediatric, neonatal, and adult ICUs. This would constitute a strategic investment and upgrading of the post-Semashko system. In addition, decisions about equipment selection have been informed by recent experience on appropriate technical specifications, reliability and maintenance costs, and validated by development partners.

Figure 1: COVID-19 Scenario modelling for Tajikistan

INPUTS		OUTPUTS						
% of population infected		Disease Impact	*Dushanbe*	*DRS*	*Sogd*	*Khatlon*	*GBAO*	***National***
		Scenario 1						
Scenario 1	***25.0%***	Severe cases (% of symptomatic cases requiring hospitalization)	7,060	16,125	22,930	23,624	2,307	**72,044**
		Critical cases (hospitalized cases requiring critical care)	1,251	3,011	4,428	4,390	500	**13,581**
		Deaths	605	1,457	2,142	2,124	242	**6,570**
		Scenario 2						
Scenario 2	***50.0%***	Severe cases (% of symptomatic cases requiring hospitalization)	14,119	32,249	45,859	47,247	4,614	**144,089**
		Critical cases (hospitalized cases requiring critical care)	2,501	6,023	8,857	8,780	1,001	**27,162**
		Deaths	1,211	2,914	4,284	4,248	484	**13,140**
		Scenario 3						
Scenario 3	***80.0%***	Severe cases (% of symptomatic cases requiring hospitalization)	22,591	51,599	73,375	75,596	7,382	**230,542**
		Critical cases (hospitalized cases requiring critical care)	4,002	9,636	14,171	14,049	1,602	**43,459**
		Deaths	1,937	4,662	6,855	6,796	775	**21,025**

Intervention impact	***Scenario 1***		***Scenario 2***		***Scenario 3***	
	Deaths averted	Critical care episodes averted	Deaths averted	Critical care episodes averted	Deaths averted	Critical care episodes averted
Case isolation in the home	131	272	263	543	420	869
Case isolation in the home and voluntary home quarantine	2,037	4,210	4,074	8,420	6,518	13,472
Case isolation in the home and voluntary home quarantine and social distancing (entire population)	854	1,766	1,708	3,531	2,733	5,650
Case isolation in the home and social distancing (entire population)	1,314	2,716	2,628	5,432	4,205	8,692
Case isolation in the home and voluntary home quarantine and social distancing (population over 70yo)	3,219	6,655	6,439	13,309	10,302	21,295
Case isolation in the home and voluntary home quarantine and social distancing (population over 70yo) and closure of schools and universities	1,905	3,938	3,811	7,877	6,097	12,603

Source: Kakietek and Ranson (2020) *for further details, including assumptions, source material and references, please see Annex 5.*

21. **The proposed activities also consider recent market dynamics for medical supplies and support from development partners, and the comparative advantages of the development institutions.** In addition, the component design also considered the recent market dynamics around global supply chains of medical supplies, and potential challenges around availability of equipment. Components were structured to limit the risk of locking up funding for supplies that are not available due to the collapse of the supply chain, and to avoid duplication, given that some United Nations' agencies (WHO, UNICEF) are better placed to ensure supplies of personal protective equipment in Tajikistan. Discussions around the activity selection have also considered equipment, supplies and materials that are already being financed by other development partners. The Pandemic Supply Chain Network is monitoring supplies of three categories of COVID-19 supplies and equipment: infection protection; diagnostics; and equipment and supplies for clinical treatment. To date, severe supply constraints are reported for infection protection supplies (with "collapse" of the market for personal protective equipment) and diagnostics. Supplies for clinical care are less constrained (as of 10 March), but market conditions are highly dynamic, and market pressures are certain to increase with COVID-19 critical cases on the rise and with some countries now placing export restrictions on supplies and equipment. The WB and the GoT will continue to actively monitor and seek to resolve procurement challenges, and significant efforts have been made to anticipate potential challenges and build in flexibility, reflecting IEG guidance and lessons learned from previous emergency response projects.

C. Relevance to Higher Level Objectives

22. **Both the SCD and the Country Partnership Framework (CPF) FY19-23 include a strong commitment to human capital and health system development, as reflected in Focus Area 1 of the WBG CPF (Human Capital and Resilience).** The need to invest in health systems to ensure the productivity capabilities of Tajik people is

recognized, as well as the challenge of overcoming a legacy of limited investment in human capital and social resilience systems. Objective 2 of the CPF focuses on enhancing health services across two areas: the first is a focus on maternal and child health and supporting water, nutrition and sanitation systems; and the second is improving the coverage and quality of basic primary health care services to improve the financial, capacity and physical infrastructure of the primary health care system. This project was not included in the CPF, but the emergency has increased the priority of health protection and treatment in Tajikistan, and the project design seeks to incorporate broader health systems strengthening measures that were envisioned in the CPF. By building the strength of the system and its resilience to shocks, it is aligned with the focus of CPF Objective 2, which focuses on improving health services. The project is also aligned with both global health priorities and IDA priorities on improving pandemic preparedness.

III. PROJECT DESCRIPTION

23. **This project was selected for COVID-19 financing as the Tajik health system has been identified as being particularly vulnerable to pandemics, scoring among the lowest in WHO EURO's assessments of operational readiness.** The scope and the components of this project are fully aligned with the COVID-19 Fast Track Facility. Activities have been carefully selected in discussion with the Deputy Prime Minister for Social Affairs, the Ministry of Finance, and MOHSP, as well as development partners, drawing on the list of eligible activities outlined in Annex 1 of the COVID-19 Board Paper. Project design also considered good practice in the component designs from other COVID-19 projects. This project complements the longer-term development work in the health sector and the focus of the CPF, including the ongoing Health Services Improvement Project, which seeks to improve the financing, organization and quality of the health system, with a focus on primary health care provision. This project has triggered paragraph 12 of the Investment Project Financing Bank Policy.

A. Development Objectives

1. The Project objectives are aligned to the results chain of the COVID-19 Strategic Preparedness and Response Program (SPRP).
2. **PDO Statement:** to prepare and respond to the COVID-19 pandemic in the Republic of Tajikistan.

PDO Level Indicators

1. Number of eligible households provided with cash transfers among affected populations.
2. Number of new fully equipped and functional intensive care beds financed by the project;
3. Number of personnel trained by the project on COVID-19 preparedness and response;

B. Project Components

24. **Component 1. Strengthening intensive care capacity (US$ 6.3 million).** As COVID-19 will place a substantial burden on inpatient services, this Component will strengthen clinical care capacity by financing specialized intensive care units in selected hospitals, the procurement of medical supplies and equipment, training, and minor refurbishment required to upgrade and expand capacity to treat patients with the most severe manifestations of COVID-19. Given the global supply chain stress and the support from other development partners in Tajikistan for a number of items, procurement under this project is prioritized for ICU patients and

health care workers. This could be extended to more broad case detection and contact tracing if pursued by the Government.

25. **Subcomponent 1.1 Infection prevention and control (US$ 1.14 million)**: This subcomponent will finance medical supplies and equipment needed to detect and prevent COVID-19 infection. The supplies and eqipment will include personal protective equipment, COVID-19 testing kits, laboratory reagents, and other consumables.

26. **Subcomponent 1.2 Improving and establishing ICUs (US$ 5.16 million)**. This subcomponent will finance the medical supplies, equipment, limited operating expenses during the crisis, training, and refurbishment needed to establish at least 100 new fully equipped ICU beds across Tajikistan. The project will not finance any construction, but rather minor refurbishment required to add new fully equipped beds to existing ICUs, or to establish new ICUs within existing hospitals. These requirements will be based on a site survey undertaken by a firm acceptable to the WB. Items procured will include equipment required for intensive care diagnosis and treatment of COVID-19 patients. The location of ICUs will be selected based on existing services and expanding geographical access to health care services in order to ensure equitable access to highly specialist care across the country. Pain medications, antibiotics and other routine medicines for the ICUs will also be financed. Staff at all ICUs (both existing and new) will receive training in COVID-19 care and infection prevention, as well as longer-term capacity building in critical care provision.

27. **Component 2. Multisectoral response planning and community preparedness (US$ 1.0 million).** This Component will support information and communication activities to increase the attention and commitment of government, private sector, and civil society, and to raise awareness, knowledge and understanding among the general population about the risk and potential impact of the pandemic and to develop multi-sectoral strategies to address the pandemic. A Strategic Coordination Advisor and a Communications Advisor would be financed under this Component to support the MOHSP in activities that will include: (a) support to a multisectoral task force to coordinate the COVID-19 emergency response in Tajikistan, and support to national, oblast (regional) and rayonal (district) bodies in mobilizing effective response activities (operating expenses, technical assistance, communication costs); (b) development of a national communications and outreach strategy and implementation plan, including social and behavioral communication change across multiple channels, and implementation of community outreach focusing on preventive and social distancing measures aligned to the national communications and outreach strategy, including the development and dissemination of communication materials adapted for target audiences in the relevant languages, and the use of Mobile Engage; (c) training of journalists on responsible reporting and emergency response procedures, covering all media types and national and regional-based outlets; (d) supporting the training and activities which are COVID-19 specific to community public health teams (consisting of primary health care workers and trained community leaders) at jamoat (community) level, coordinated by the Republican Center for Healthy Lifestyles, to increase awareness of preventive measures, to support case detection and contact tracing if pursued by the Government, and to promote community participation in slowing the spread of the pandemic.

28. **Component 3. Temporary social support for vulnerable households (US$ 3.0 million).** This Component will finance targeted, nutrition-sensitive cash transfers to provide time-limited support to vulnerable households, particularly food insecure households with young children where food price shocks caused by the COVID-19 pandemic can negatively affect children's nutrition status and jeopardize the human capital investments being made by the Government of Tajikistan and the WB. The transfers will be delivered using the existing Targeted Social Assistance (TSA) system implemented by the State Agency for Social Protection (SASP). Annex 2 presents in greater depth the rationale for including cash transfers as part of this operation and provides a summary of the current

program. The TSA system includes an additional module to allow for additional payments in emergency situations and the eligibility criteria can be adapted to target the most food insecure communities. The transfers will be triggered at the oblast-level based on the spikes in the prices of key food groups (wheat, milk and dairy, eggs). Food prices in each oblast will be monitored through the routine market monitoring systems of the Ministry of Economic Development and Trade. A specific price increase threshold will be identified in consultation with the MOHSP, SASP, and key technical partners: WFP and UNICEF. Once triggered, the program will target TSA beneficiary households with young children, to be further defined in the POM. This component will finance the cash transfers, and cover the costs of benefit administration, including the cost of expanding capacity of the beneficiary data base. The proposed cash transfers will also provide an opportunity to use accompanying measure to promote optimal nutrition, appropriate hygiene, and preventive health services, as well CoVid19 infection prevention messaging (the development of the communication materials will be financed under Component 2). This component has been designed with potential for scale up in mind, recognizing that further financing may become available following this initial phase of emergency response.

29. **Component 4. Project Implementation and Monitoring (US$ 1.0 million).** Implementing the proposed Project will require administrative and human resources that exceed the current capacity of the implementing institutions. For this reason, building on the existing strong project management capacity is critical for rapid implementation and scale-up of project activities.[7] The MOHSP will receive professional implementation and project management support, including for procurement and financial management (FM), from a designated new Project Implementation Unit (PIU). The core of the new PIU will be formed from the team of the well-functioning Project Implementation Unit of the Tajikistan Social Safety Nets Strengthening Project (SSNSP), which is closing on June 30, 2020. The Emergency COVID-19 Response Project will contract a progressively increasing share of staff time from the SSNSP PIU staff on a single-source basis (50 percent or more, as feasible and warranted, initially and 100 percent upon SSNSP closure). These staff include: Project Coordinator, FM Management Specialist, Procurement Specialist, 3 IT Specialists, and Administrative Assistant. Additional necessary staff will be recruited to the PIU as needed (with agreed upon terms of reference which have received the WB's no goog), such as an Environmental and Social Safeguards Officer, a Monitoring and Evaluation Specialist, Interpreter/Translator, and specialized technical staff. This component also intends to support building the capacity of the country for more sustainable response planning in the future. It will also be important to monitor remittance level and distributions, in terms of household wealth. This Component will also support the monitoring and evaluation of project activities. Activities that will be financed include: (a) support for project management, including procurement, FM, environmental and social safeguards, monitoring and evaluation, and reporting; (b) operating costs; (c) project audits.

C. Project Beneficiaries

30. The expected project beneficiaries will be infected people, at-risk and food insecure populations, medical staff and national coordination bodies.

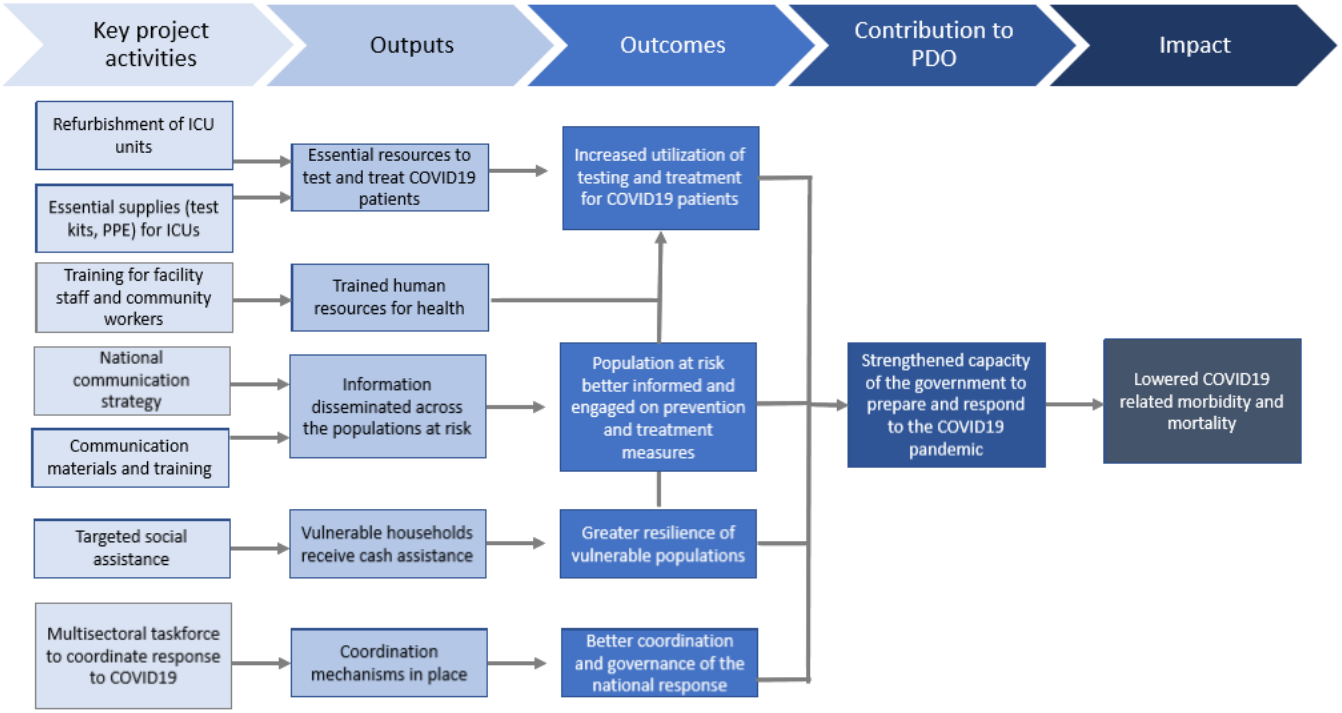
[7] The rationale for using the SSNSP PIU over the Technical Support Group (TSG) of the Health Services Improvement Project (HSIP), both under the same MOHSP, is as follows: (i) strong performance and sustainable team dynamic over the whole 5-year implementation period of the SSNSP under MOHSP; (ii availability of freed up staff time given approaching closing date of the SSNSP; (c) forthcoming implementation of innovative activities under second additional financing for the HSIP, which by itself would be a challenging task and put additional strains on the TSG of HSIP; and (iv) substantially weakened capacity of the HSIP TSG team owing to the recent departure of two experienced key staff: Project Officer (head of TSG) and Procurement Specialist.

D. Results Chain

31. Swift detection of an outbreak, assessment of its epidemic potential and rapid emergency response can reduce avoidable mortality and morbidity and reduce the economic, social, and security impacts. Failure in the rapid mobilization of financing and coordination of response results in unnecessary casualties and significant socioeconomic consequences. By focusing on the containment, diagnosis and treatment of patients, this project seeks to control the disease outbreak and limit socioeconomic losses.

32. At the facility level, through investments in refurbishments of ICUs, and the provision of basic equipment and medical inputs (test kits, personal protective equipment), and training of facility personnel in COVID-19 prevention and treatment protocols, the Project will strengthen the resources needed to respond to the surge in the number of COVID-19 cases, which will lead to an increase in the utilization of testing and treatment services. By supporting a multisectoral taskforce at the national and local levels, the Project will improve the coordination of the response to COVID-19 among various government agencies and international partners. By investing in the development of a communication strategy and its implementation, the Project will increase the level of information disseminated to the population at risk. By investing in community public health teams, the Project will help increase the awareness of and engagement of communities with preventive and treatment measures. By investing in targeted social support, the Project will increase the resilience of food insecure households and enable them to use prevention and treatment services. Together, these investments will increase the capacity of the Government of Tajikistan to respond to this and future pandemics and, ultimately, decrease COVID19-related morbidity and mortality in Tajikistan.

Figure 1: Results Chain



E. Rationale for Bank Involvement and Role of Partners

33. The WB's dedicated umbrella COVID-19 Response Program and IFC's Trade Solutions and Working Capital Liquidity Facilities build on the experience and credibility of both institutions in responding to global crisis. They allow the institutions to move nimbly to support countries as they respond to the health and economic impacts of the spread of COVID-19 and build in the experience and high standards that are needed so that the approaches work well in fast moving environments.

34. The WB, in concert with the international community, can play a key role in the response to COVID-19 following the technical lead of WHO. The WHO is in the process of finalizing the health sector operational plan for Tajikistan, and this draws from global emergency response plans being led by the WHO. The global activities and framework should address both animal and public health aspects as well as economic impact. Many of the investments needed to address this disease are core public health and animal health functions that are considered "global public goods", thus, necessitating a global and regional response with support from the international community. Annex 2 provides a summary of the role of other development partners. As noted above, there have been considerable efforts to coordinate with other partners to ensure that WB financing fills a financing gap and constitutes the most effective investment possible.

F. Lessons Learned and Reflected in the Project Design

35. The WB is well positioned to respond to this pandemic given its global expertise combined with understanding of country conditions and needs, prior experience in responding to crises (pandemics, natural disasters, economic shocks, etc.) while building resilience and improving future preparedness and response capability, respect and trust of client countries, and global partnerships (the United Nations' agencies/WHO, other Multilateral Development Banks, IMF, etc.). The proposed first instance response will address elements of the emergency COVID-19 response that are not being financed by other partners, allowing a rapid response to immediate needs. Depending on how the outbreak progresses and impact on economic activity unfolds there may be need for a second phase with a greater focus on support to ameliorate economic and social disruption resulting from the spread of the virus.

36. The Fast Track COVID-19 Facility and the proposed operation draw upon lessons learned from previous WB responses to recent global crises and outbreaks, including the various Ebola outbreaks, the Global Food and Avian Influenza Crises in 2007-08, and the 2017 Food Crisis Response, among others. Swift detection of an outbreak, assessment of its epidemic potential and rapid emergency response can reduce avoidable mortality and morbidity, as well as reduce the economic, social, and security impacts. Failure in the rapid mobilization of financing and coordination of response results in unnecessary casualties and significant socioeconomic consequences. As highlighted by the SARS and the West African Ebola Virus Disease (EVD-WA) outbreak, the cost of outbreak control and socioeconomic losses rises exponentially with delayed detection, reporting, and action, and close technical coordination is needed across countries to prevent and control the transboundary spread of the disease. Although delayed by several months from the onset of cases, the global response to EVD-WA was eventually effective in stopping the outbreak. The failure in the rapid mobilization of financing and the coordination of response resulted in unnecessary casualties of over 11,000 persons, and significant socioeconomic consequences across the sub-region. These economic and social costs of the EVD-WA crisis are estimated to be US$53 billion.[2]

37. Use of an umbrella programmatic approach adaptable to a country's needs can also facilitate a flexible rapid response. Such programmatic approaches also help to reduce project preparation times[3], enabling countries to choose from a menu of relevant activities depending on country conditions, and can provide such a platform for high-level policy and regulatory harmonization, cooperation, and coordination between countries,[4] especially in times of emergency.

IV. IMPLEMENTATION ARRANGEMENTS

A. Institutional and Implementation Arrangements

38. **Intersectoral coordination and steering level.** The government-level Standing Headquarters, established in February 2020 and formalized with a resolution from the President (No. AP-1365) on 18 March 2020, is composed of representatives from relevant ministries, agencies, and development partners. Led by the Prime Minister, it will provide a steering role for the overall national response, and for the project interventions specifically.

39. **Implementation level.** The MOHSP will be the overall implementing agency for the Project. SASP will ensure the implementation of Component 3 (temporary social support for vulnerable households), given that this agency is responsible for the overall TSA system. The MOHSP is the designated central operational body within the Government and Standing Headquarters, which is also responsible for coordination and liaison with development and humanitarian partners. The Minister of Health and Social Protection will be the Project Director. The Minister of Health and Social Protection will delegate day-to-day operational issues, including Project signatory rights in procurement, financial management etc., to the Deputy Minister of Health and Social Protection acceptable to the Association, who will be the Project Coordinator. The Project Coordinator will report twice a month to the Standing Headquarters and Prime Minister on project activities as part of the overall COVID-19 response.

40. The MOHSP's Division of Sanitary and Epidemiological Safety, Emergencies and Emergency Medical Care (DSESEEMC) will be responsible for the day-to-day management and coordination of COVID-19 response activities supported under Components 1 and 2 of the Project. Component 3 activities will be coordinated with the MOHSP's Division for Social Protection of Population (DSPP) and technically managed by the SASP under the MOHSP. The MOHSP's Division for Health Care Economics and Budget Planning will be overseeing proper and timely execution of FM functions and funds flow under the Project. In addition, other technical divisions at the MOHSP, research institutes, national medical services, regional and local health authorities, community councils, religious leaders, and other key agencies will be involved in project activities based on their functional capacities and institutional mandates.

41. The new PIU will support the DSESEEMC and SASP/DSPP, and directly implement certain technical activities, including procurement of medical supplies, equipment, and facility repurposing works for activities under Component 1 as well as selected activities under Component 2. The PIU will also be responsible for preparing a consolidated annual workplan and a consolidated activity and financial report for the project components. For Components 1 and 2 directly related to COVID-19, the PIU will report to the Deputy Minister of Health and Social Protection/National Coordinator for COVID-19 Counteraction; while for Component 3, the PIU will report to the Deputy Minister of Health and Social Protection in charge of social protection area through SASP similar to the current arrangements for SSNSP. A Project Operational Manual (POM) clearly describing the roles, responsibilities, and processes will be prepared and adopted by the MOHSP within one month of the Effectiveness Date. The

Recipient shall by no later than one (1) month after the Effective Date, prepare and adopt a Project operations manual.

42. **Project Implementation Agreement and Project Operational Manual.** These implementation arrangements will be detailed in a Project Implementation Agreement, which will clearly describe the roles and responsibilities for implementing all components under this Project. A Project Operational Manual will also be developed and will describe all implementing processes in more detail. The Project Implementation Agreement will be an Effectiveness Condition, whereas the Project Operational Manual will be prepared and adopted no later than one month after the Effective Date.

B. Results Monitoring and Evaluation Arrangements

43. Through the PIU, the DSESEEMC and SASP will be responsible for (a) collecting and consolidating all data related to their specific suite of indicators; (b) evaluating results; (c) providing the relevant performance information to the respective Deputy Ministers and Standing Headquarters; and (d) reporting results to the WB immediately prior to each semi-annual supervision mission. Each MOHSP Division engaged in project activities, SASP, and PIU will perform their project-related functions in accordance with the methodology prescribed in the POM. Each such MOHSP Division will also appoint a focal point to ensure timely provision of project monitoring data.

C. Sustainability

44. The sustainability of the project would largely depend on the capacity of the implementing agencies and the specific activities. The focus of some of the project activities on training and intensive care capacity building will further enhance the sustainability of the project. Building on IEG guidance about the sustainability challenges of mechanisms to compensate macro-fiscal impacts, the WB will continue to work with the Ministry of Finance and MOHSP to assess the need for additional financing for social safety net aspects. The current project design will be to focus on emergency response and look for opportunities to follow-up and provide support both public health and macro-fiscal support in the aftermath of the outbreak's epidemiological peak.

V. PROJECT APPRAISAL SUMMARY

A. Technical, Economic and Financial Analysis (if applicable)

45. In addition to its heavy health and human toll, the COVID-19 outbreak further clouds an already fragile global economic outlook and can further set back the fight against poverty. Potential tightening of credit conditions, weaker growth and the diversion of expenditures to fight the outbreak are likely to cut into government revenues and governments' ability to invest to meet education, health and gender goals. The poor will be hit particularly hard. Current estimates suggest that a 1 percent decline in developing country growth rates traps an additional 20 million people into poverty.

46. The outbreak weighs on economic activity through both demand and supply channels. On the demand side, activities involving face-to-face interaction are heavily affected. On the supply side, prevention measures, such as factory closures, have significantly disrupted production of tradable and non-tradable goods across the

country. Available high-frequency data point to a major contraction in economic activity in China this quarter. These include sharp downturns in daily coal consumption for power generation, average road congestion, nationwide passenger traffic, tourism activity, and container throughput at Chinese ports. A month after Chinese New Year, daily passenger trips are down 80% compared to normal. Most international carriers have cancelled their flights to China until at least end-April. Container shipping lines have been idling vessels at a record pace in January-February. At end-February, coal use was half of last year's in major power generation plants with daily reporting; pollution, an indicator of industrial production, was down 40 percent compared to normal. As of mid-February, Morgan Stanley has estimated industrial production at 30-50 percent of normal. Moreover, production indicators for electronics have faltered, suggesting growing disruptions to China's globally-integrated manufacturing sector. In this context, the manufacturing PMI suffered its worst performance

B. Fiduciary

(i) Financial Management

47. The project will be implemented by the MOHSP with the fiduciary support from the PIU provided to the MOHSP. In addition, the existing cash flow arrangements at SASP will be relied on for channeling cash transfers under Component 3 to provide time-limited support to vulnerable households. The FM assessment for the project was conducted in accordance with the Financial Management Manual for World Bank Investment Project Financing Operations that became effective on March 1, 2010 but was revised on February 10, 2017. The assessment confirmed that the FM arrangements (budgeting, accounting, reporting, internal control, staffing, funds flow and audit) under the project are adequate to implement the project and meet the minimum requirements of OP/BP 10.00. They also take into consideration OP 8.00 on Rapid Response to Crises and Emergencies and Guidance Note on FM in Rapid Response to Crises and Emergencies. The MOHSP does have experience in implementing WB health projects and currently carries out the FM function for the Health Services Improvement Project (P126130). The existing PIU of SASP will form a core team of the new PIU to support the MOHSP in performing fiduciary functions. This PIU is currently involved in implementation of WB-funded Social Safety Nets Strengthening Project (P122039), which is closing in June 30, 2020. The PIU has an experienced FM specialist, who works for the ongoing project and will be assigned to support the MOHSP Chief Accountant in carrying out FM functions under the Emergency COVID-19 Response Project. Internal audit arrangements are in place to oversee the operations of the project. The project accounts will be prepared in line with Cash Basis International Public Sector Accounting Standards. For the ongoing SSNSP project the PIU utilizes 1C accounting software, which is adequate and will be used for the Emergency COVID-19 Response Project's accounting and financial reporting. No major upgrade to the software is required, and the PIU will update it to reflect the Emergency COVID-19 Response Project's specific components, and categories. An Action Plan has been agreed to be implemented to strengthen the FM arrangements under the Emergency COVID-19 Response Project. These actions include updating: (a) the contract of the existing PIU's FM Specialist to perform fiduciary functions under the project; (b) the existing PIU's FM Manual as part of POM; and (c) the existing PIU's accounting software for the project to have the capacity to generate unaudited interim financial reports (IFRs) as well as attachments of withdrawal applications including statement of expenditures and annual financial statements. All these actions should be completed within 30 days of Project effectiveness.

48. The SASP role in the FM arrangements for the Emergency COVID-19 Response Project will be limited to channeling cash transfers and preparing respective financial reporting on the use of the funds under component 3 for the project, with assistance provided by PIU. For the cash transfers, it is expected that upon MoF's request the funds would be disbursed to a SASP's account at the state treasury for further transferring to the beneficiary's personal bank accounts. To enable separate accounting and reporting for the cash transfers under this project, the

SASP will open a separate sub-account in the treasury system specifically dedicated to those funds. The funds will finance eligible expenditures (nutrition-sensitive cash transfers to provide time-limited support to food insecure households with young children). The SASP will make cash transfers to eligible Beneficiaries, through the Targeted Social Assistance system, in accordance with additional eligibility criteria and procedures acceptable to the Bank, as described in the POM (to be produced within 30 days after effectiveness). The fund distribution to Beneficiaries will be tracked using electronic management information system of SASP, including National Registry for Social Protection. The SASP will periodically generate and submit to the PIU operational and financial reports on utilization of the project funds for cash transfers. The PIU will consolidate the reports for preparation of quarterly Interim Unaudited Financial Reports (IFR). SASP reports will also be used to request replenishment of the SASP special sub-account for subsequent transfer payments. The project funds for this activity will be disbursed after the adoption by the Government of a decree mandating nation-wide rollout of the Targeted Social Assistance, acceptable to the Bank.

49. The current auditing arrangements at the PIU for the ongoing Bank-financed SSNSP project are adequate, and the Emergency COVID-19 Response Project will rely on those arrangements for the audit. There are no overdue audits under the ongoing project. The audit reports, with unmodified opinions, were received by the Bank on time with no critical issues in the management letters nor ineligible issues identified. The audit of the project financial statements will be conducted by (i) independent private auditors acceptable to the Bank, on Terms of Reference acceptable to the Bank, and (ii) according to the International Standards on Auditing issued by the International Auditing and Assurance Standards Board of the International Federation of Accountants. Annual audited project financial statements will be submitted to the Bank within six months after the end of each fiscal year, also at the project closing. The auditor will also review sample transactions of cash transfers made by SASP under the project's Component 3 to confirm the eligibility of the respective expenditures.

50. The recipient has agreed to disclose the audit reports for the project, within one month of their receipt from the auditors, by posting the reports on the website of the MOHSP. Following the Bank's formal receipt of these reports from the Recipient, the Bank will make them publicly available according to World Bank Policy on Access to Information.

51. Quarterly IFRs will be used for Project monitoring and supervision. These financial reports will be submitted to the Bank within 45 days of the end of each calendar quarter. As part of the project implementation support and supervision missions, quarterly IFRs, audit reports and audit management letters will be reviewed, and regular risk-based FM missions will be conducted. The project will receive disbursements from the Bank through advances using statements of expenditure, direct payments, reimbursements and commitments e.g. letters of credit. Details with respect to disbursements will be included in the Disbursement and Financial Information Letter.

52. **Retroactive financing.** A clause on retroactive financing has been included in the Loan Agreement as governed by Bank policy (OP 10.0, Paragraph 12, revised July 1, 2014). Retroactive financing, if needed, will be up to 40 percent of the total Grant and will be used for reimbursement of eligible expenditures incurred on or after March 20, 2020, but in no case more than 12 months prior to the Signature Date.

53. The overall FM residual risk rating was assessed as Substantial. Should FM risks materialize, the impact on the achievement of the PDO would be substantial.

(ii) Procurement

54. Procurement for the project will be carried out in accordance with the World Bank's Procurement Regulations for IPF Borrowers for Goods, Works, Non-Consulting and Consulting Services, dated July 1, 2016 (revised in November 2017 and August 2018). The Project will be subject to the WB's Anticorruption Guidelines (ACG), dated October 15, 2006, revised in January 2011, and as of July 1st, 2016 and the provisions stipulated in the Financing Agreement. Given the emergency nature of this project, simplified procurement procedures for works and goods and selection procedures for consultant services may apply in accordance with the Bank Guidance: Procurement in Situations of Urgent need of Assistance or Capacity Constraints, dated March 7, 2019. It is foreseen that the Recipient may take advantage of Advance Contracting and/or Retroactive Financing, and the Letter of Acceptance of the Bank's ACG and Suspension Framework will be used in the Bidding Documents/Invitations and Contracts/Purchase Orders. Nevertheless, a partial waiver of the ACG may be required in some cases. The retroactive financing may be applied to the contracts procured in advance for the purpose of this Project objective using procurement procedures consistent with Sections I, II and III of the Bank's Procurement Regulations and consistent with the Financing Agreement of this Project. The Project will use the Systematic tracking of Exchanges in Procurement (STEP) to plan, record and track procurement transactions for all contracts.

55. The Recipient has prepared a streamlined Project Procurement Strategy for Development (PPSD), and initial procurement plan for the entire project that will be finalized during the project implementation. It will specify procurement approaches and methods, as well as provide the thresholds for selection methods as agreed with the Bank. While all methods as specified under Procurement Regulations can be used, given the emergency nature of this project, the most streamlined and simple procurement methods will be first considered. These include Direct procurement, Request for Quotations (RFQ) with no threshold limit for this method as appropriate, Consultants qualifications-based selection. Tender commissions shall be limited to 3-5 essential people.

56. The proposed procurement approach prioritizes fast track emergency procurement for the emergency required goods, works and services. Key measures to fast track procurement include the use of the most effective methods fit for an emergency situation as direct contracting and/or streamlined competitive procedures, including under national procedures and existing framework contracts. These include Bid Securing Declaration may be asked in lieu of a guarantee; Performance Security may not be required for small contracts; Advance payment may be increased to 40% while secured with the advance payment guarantee; The time for submission of bids/proposal can be shortened to 15 days in competitive national and international procedures, and to 5 days for the Request for Quotations depending on the value and complexity of the requested scope of bid. Procurement through UN agencies can also be enabled and expedited by Bank procedures and templates.

57. The Bank can also provide Hands-on Expanded Implementation Support (HEIS) to the Government of Tajikistan at all stages of the procurement – from help with supplier identification, to support for bidding/selection and/or negotiations to contract signing and monitoring of implementation.

58. **This can be augmented by Bank-Facilitated Procurement (BFP).** Recognizing the significant disruptions in the usual supply chains for medical supplies, the Bank can augment its hands-on support, at the request of the Government of Tajikistan, to proactively assist in accessing existing supply chains. Once the suppliers are identified, the Bank could proactively assist the Government of Tajikistan with negotiating prices (on the basis of aggregated demand across countries, whenever possible), delivery, and other contract conditions, as requested. While the Government of Tajikistan will remain responsible for signing and entering into contracts and implementation,

including assuring relevant logistics with suppliers, the Bank could also help in outsourcing logistics, as needed. This more proactive role will aim to help the Government of Tajikistan get access to critically needed supplies, if and as needed. All other procurement options mentioned above remain available depending on the preference of the Government of Tajikistan in order to provide the most efficient and effective support to projects in the specific circumstances. This expanded role will be performed by the Bank in coordination with UN agencies and possibly governments, who may have available stock. Direct payment by the Bank will be a very important incentive, especially in the present market conditions.

59. Procurement will be carried out by the MOHSP through the designated PIU with a core team currently implementing the SSNSP Project. The SSNSP team has extensive experience with the WB procedures with procurement performance consistently rated as "Satisfactory". Streamlined procedures for approval of emergency procurement to expedite decision making and approvals by the Recipient have been agreed.

60. The major risks to procurement are: (a) the global nature of the COVID-19 outbreak that creates shortages of supply and the necessary services (this may result in increased prices and cost, particularly for equipment that is at high demand globally such as ventilators and ICU patient bed monitoring devices); (b) border closures and restrictions causing supply chain risk (these restrictions may affect timely delivery of essential goods and services); and (c) delays and slow decision making due to attributed to the lack of familiarity of the Recipient in dealing with such a novel epidemic. The procurement risk is **High**. These risks will be mitigated by the increased implementation support; increased procurement post review based on a 20 percent sample while prior review will not apply; established procurement streamlined procedural measures.

C. Legal Operational Policies

	Triggered?
Projects on International Waterways OP 7.50	No
Projects in Disputed Areas OP 7.60	No

D. Environmental and Social

61. Consistent with the principles embedded in the ESF policy, Environmental and Social activities shall be timed and sequenced to fit the needs and risks of the project, with a particular focus on (i) the development of waste management plans; (ii) worker safety; (iii) community safety plans; and (iv) communications and stakeholder engagement. The relevant Environment and Social documentation is standardized and streamlined, as feasible. Given that dissemination of information to the affected and neighboring communities is critical, and cooperation by and communication with the population is key to the success of this project, an important component of this project is a comprehensive stakeholder engagement plan.

VI. GRIEVANCE REDRESS SERVICES

62. Communities and individuals who believe that they are adversely affected by a WB supported project may submit complaints to existing project-level grievance redress mechanisms or the WB's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address project-related

concerns. Project affected communities and individuals may submit their complaint to the WB's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WB non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the WB's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the WB's corporate Grievance Redress Service (GRS), please visit http://www.worldbank.org/en/projects-operations/products-and-services/grievance-redress-service. For information on how to submit complaints to the WB Inspection Panel, please visit www.inspectionpanel.org.

VII. KEY RISKS

63. The **overall Project risk rating is Substantial.** Risks in four of the eight categories are rated **Substantial** and one, macroeconomic, is rated **High**. Substantial risks include: political and governance risks, sector strategies and policies, fiduciary risks, and environmental and social risks. Institutional capacity for implementation and sustainability, technical design, and stakeholder risks are rated as **Moderate**. The Project is a bold and well-grounded response to the COVID-19 pandemic, in a country marked by limited public sector capacity, a weak health system, and widespread food insecurity.

64. **While a considerable degree of risk is inherent in a project of this urgency, important mitigation measures have been integrated into its design.** Project activities including support to the health system and social protection against the economic shock of the pandemic provide some mitigation for the macroeconomic risks, however the factors outlined in the country context leave the residual risk for this category as **High**. There are signs of strong political commitment from the elevation of the leadership of the Standing Headquarters from the Deputy Prime Minister to the Prime Minister in March 2020, however the residual political and governance risks are rated **Substantial.** While the Project will support the development of additional policies, such as a national communications strategy, that will deepen the pandemic response, current sector strategies and policies do not provide a strong enabling environment for a coordinated response, leaving this risk as **Substantial**. To support the emergency response, this project will utilize rapid disbursement procedures and simplified procurement processes in accordance with emergency operations norms. A specific fiduciary risk is failed procurement due insufficient global supply of essential medical consumables and equipment needed to address the health emergency as there is significant disruption in the supply chain, especially for PPE. To help mitigate this risk, the Bank may leverage its comparative advantage as convener and facilitate access to available supplies at competitive prices if requested as described in the procurement section of this document. Given previous challenges ensuring fiduciary oversight in emergency projects, however, the residual fiduciary risks are **Substantial**. Despite supporting policies and plans, environment and social risks are rated **Substantial** for the same reason. The Project will support technical assistance and the development of partnerships between local organizations and international expertise, however given the scale of the challenge the risk of institutional capacity for implementation and sustainability is rated **Moderate**. The technical design was developed in alignment with the Government of Tajikistan's Emergency Response Plan and support committed by other development partners, and the residual risk given the fast-evolving nature of the pandemic is rated **Moderate**. Similarly, the project will support government coordination, communication, and community outreach activities to sensitize key groups including mass media, leaving the residual risk for stakeholders as **Moderate.**

VIII. RESULTS FRAMEWORK AND MONITORING

Results Framework

COUNTRY: Tajikistan

Tajikistan Emergency COVID-19 Project

Project Development Objective(s)

Project Development Objective (PDO) is to prepare and respond to the COVID-19 pandemic in the Republic of Tajikistan.

Project Development Objective Indicators

Indicator Name	DLI	Baseline	End Target
To prepare and respond to the COVID-19 pandemic in the Republic of Tajikistan.			
Number of beds in fully equipped and functional intensive case units (ICUs) financed by the project (Number)		0.00	100.00
To prepare and respond to the COVID-19 pandemic in the Republic of Tajikistan.			
Number of health personnel trained by the project on CoVid19 preparedness and response (Number)		0.00	1,000.00
To prepare and respond to the COVID-19 pandemic in the Republic of Tajikistan.			
Number of vulnerable who households received targeted cash assistance financed by the project (Number)		0.00	30,000.00

Intermediate Results Indicators by Components

Indicator Name	DLI	Baseline	End Target
Strengthening intensive care capacity.			
Number of PPE units procured by the project. (Number)		0.00	300,000.00
Number of ventilators procured by the project. (Number)		0.00	100.00
Number of COVID -19 test kits procured by the project. (Number)		0.00	1,200.00
Multi-sectoral response planning and community preparedness.			
A communication and outreach strategy financed by the project is developed and approved by the Multisectoral Task Force (Yes/No)		No	Yes
Number of community volunteers trained by the project (Number)		0.00	1,000.00
Project Implementation and Monitoring			
Percentage of grievances addressed within the time specified in the project implementation manual (Percentage)		0.00	80.00
Temporary social assistance for vulnerable households			
Beneficiaries of social safety net programs (CRI, Number)		0.00	30,000.00
Beneficiaries of social safety net programs - Female (CRI, Number)		0.00	0.00
Beneficiaries of Safety Nets programs - Unconditional cash transfers (number) (CRI, Number)		0.00	30,000.00
Beneficiaries of Safety Nets programs - Social Pensions (number) (CRI, Number)		0.00	0.00
Beneficiaries of Safety Nets programs - Other cash transfers programs (number) (CRI, Number)		0.00	0.00
Beneficiaries of Safety Nets programs Ã¢â¬â School feeding programs (number) (CRI, Number)		0.00	0.00
Beneficiaries of Safety Nets programs - In-kind transfers (number) (CRI, Number)		0.00	0.00

Indicator Name	DLI	Baseline	End Target
Beneficiaries of Safety Nets programs - Cash-for-work, food-for-work and public works (number) (CRI, Number)		0.00	0.00
Beneficiaries of Safety Nets programs - Other social assistance programs (number) (CRI, Number)		0.00	0.00

Monitoring & Evaluation Plan: PDO Indicators

Indicator Name	Definition/Description	Frequency	Datasource	Methodology for Data Collection	Responsibility for Data Collection
Number of beds in fully equipped and functional intensive case units (ICUs) financed by the project	Cumulative number of intensive care beds fully equipped ICUs financed by the project. "Fully equipped and functional" will be defined in the project implementation manual (PIM) in accordance with the international and national norms and protocols.	Every 9 months	PIU data base	Facility audit	MoHSP and PIU
Number of health personnel trained by the project on CoVid19 preparedness and response	Cumulative number of health personnel trained by the project on CoVid19 preparedness and response	Every 6 months	PIU data base	PIU data base	MOHSP, PIU
Number of vulnerable who households received targeted cash assistance	Cumulative number of vulnerable households	Every 6 months	TSA data base	TSA routine reports	MOHSP, TSA

financed by the project	received one-time targeted cash assistance financed by the project				

Monitoring & Evaluation Plan: Intermediate Results Indicators					
Indicator Name	**Definition/Description**	**Frequency**	**Datasource**	**Methodology for Data Collection**	**Responsibility for Data Collection**
Number of PPE units procured by the project.	Cumulative number of surgical masks for health care providers working in the ICUs procured by the project. The technical specifications of the masks will be defined in the project implementation manual based on the international/national norms and standards for CoVid19 response.	Every 6 months	PIU procurement data	PIU procurement data	PIU
Number of ventilators procured by the project.	Cumulative number of ventilators procured by the project. The technical specifications of the ventilators will be defined in the project implementation manual based on the international/national norms and standards for CoVid19 response.	Every 6 months	PIU procurement data	PIU procurement data	PIU

Number of COVID -19 test kits procured by the project.	Cumulative number of test kits procured by the project. The technical specifications of the kits will be defined in the project implementation manual based on the national norms and standards for CoVid19 response.	Every 6 months	PIU procurement data	PIU procurement data	PIU
A communication and outreach strategy financed by the project is developed and approved by the Multisectoral Task Force	Communication and outreach strategy and an implementation plan financed by the project is developped and approved by the Multisectoral Task Force	Every 18 months	Multisectoral Task Force	Multisectoral Task Force	Multisectoral Task Force
Number of community volunteers trained by the project	Cumulative number of community workers trained on the key issues related to CoVid19 by the Center for Healthy Lifestyles based on the international and national protocols	Every 6 months	PIU data	PIU training records	MOHSP and PIU
Percentage of grievances addressed within the time specified in the project implementation manual	Percentage of grievances related to project implementation and submitted to the PIU addressed within the time specified in the project implementation manual	Every 6 months	PIU data	PIU data	PIU

Beneficiaries of social safety net programs		Every 6 months	TSA data base	TSA reports	MOHSP, SASP
Beneficiaries of social safety net programs - Female					
Beneficiaries of Safety Nets programs - Unconditional cash transfers (number)		Every 6 months	TSA database	TSA reports	MOHSP, SASP
Beneficiaries of Safety Nets programs - Social Pensions (number)					
Beneficiaries of Safety Nets programs - Other cash transfers programs (number)					
Beneficiaries of Safety Nets programs Ã¢â¬â School feeding programs (number)					
Beneficiaries of Safety Nets programs - In-kind transfers (number)					
Beneficiaries of Safety Nets programs - Cash-for-work, food-for-work and public works (number)					
Beneficiaries of Safety Nets programs - Other social assistance programs (number)					

ANNEX 1: Project Costs

COUNTRY: TAJIKISTAN
Tajikistan Emergency COVID-19 Project

COSTS AND FINANCING OF THE COUNTRY PROJECT

Program Components	Project Cost	IDA Financing	Trust Funds	Counterpart Funding
Component 1: Strengthening intensive care capacity	6.3	6.3		
Component 2: Multisectoral response planning and community preparedness	1.0	1.0		
Component 3: Temporary social assistance to vulnerable households	3.0	3.0		
Component 4. Project implementation and monitoring	1.0	1.0		
Total Costs	11.3	11.3		
Total Costs	11.3			
Front End Fees				
Total Financing Required	11.3			

ANNEX 2: Overview of Development Partners' Contributions

This table summarizes the contributions of development partners to the COVID-19 emergency response in Tajikistan to the best of the WB's knowledge as of March 25, 2020.

Organization	Supplies & equipment	Technical support (provided directly or through third party)	Approximate value
Donated / disbursed or under implementation:			
KfW	IPC (Infection Protection Control) supplies, medical equipment	Training related to medical equipment use	$1,075,000
United States Agency for International Development (incl. through Abt Associates)	IPC supplies and equipment, PCR machines, diagnostics	IPC; laboratory capability; surveillance and rapid response; case management; risk communication and community engagement; points of entry	Approx. US$ 1m
World Health Organisation	IPC supplies, diagnostics	International coordination and operational support, scaling up country readiness and response operations, development of "operational plan for COVID-19"	Not available
Asian Development Bank	IPC supplies (To be confirmed)	-	US$ 100,000
Open Society Institute Assistance Foundation Tajikistan	-	Strengthening country and civil society capacities to prevent and respond	US$ 100,000
UNICEF (including with SDC funding)	IPC supplies, behavioral change communication, communications materials	IPC; population awareness	US$ 77,000 (US$ 200,000 under discussion)
Aga Khan Development Network (including with SDC funding)	IPC supplies, support for quarantine	Training of health workers.	US$ 64,000
MSF	IPC supplies, diagnostics	-	Not available
PASHA	IPC supplies	-	US$ 2,000
Russia	Diagnostics	-	Not available
United Kingdom (Public Health England)	-	Re-testing negative lab tests.	Not available
Japan International Cooperation Agency	-	Research to strengthen health system through PHC.	Not available
Support not yet committed:			
Global Fund to Fight AIDS, Tuberculosis and Malaria	Awaiting request from MOHSP; likely lab consumables.	-	Up to US$ 300,000
European Commission	-	Strengthening country capacities to prevent, detect and respond, including multi-sectoral engagement.	TBD
Gavi, the Vaccines Alliance	Request under review by Gavi	-	TBD

ANNEX 3: Summary of current Targeted Social Assistance (TSA) Program in Tajikistan

1. **The TSA Program is in the rollout phase and, so far, has reached 40 out of 64 districts of the country.** A TSA pilot, in place of 2 legacy programs, was launched in Yovon and Istaravshan districts in January 2011 to deliver a consolidated social assistance benefit to households in the poorest 20 percent of the population; the European Union provided initial support to the pilot. Following successful evaluation, over the years the TSA was extended considerably, and it currently covers about 100,000 households in 40 districts of Tajikistan. It uses proxy means testing as a targeting tool and maintains a centralized electronic database of records of beneficiaries.

2. **There have been several rounds of evaluation of the TSA program and mechanisms:**

(a) In 2012, a rigorous impact evaluation of the pilot showed that the program improved targeting (a greater share of benefits accrues to the poor compared to the legacy programs), generated positive satisfaction from the program by the population, improved the perceived financial situation, improved perception of food security among beneficiaries and raised actual food consumption by 16-25 percent.

(b) In 2019, another impact evaluation was launched, with a nation-wide survey covering close to 4,000 households; results of the analysis are expected later in 2020.

(c) Between 2018-2019, several rounds of beneficiary satisfaction assessments were conducted. In 2018, the focus group interviews in various districts indicated that beneficiaries: (i) appreciate the assistance extended by the government, including a broader package of services that comes with the TSA eligibility; (ii) see the reduction in the discretion and nepotism of the local authorities as the decisions on eligibility are made automatically; and (iii) often spend the assistance on paying off arrears in energy cost. In 2019, as part of the nation-wide household survey, the TSA beneficiary feedback was collected, and broadly reconfirmed these findings.

(d) In 2019, a rapid operational evaluation indicated that the TSA has significant buy-in among the administrators of the program and among the population. The mechanisms of operational and financial controls engage several government bodies and provide for transparent, efficient and reliable operation of the system, as well as an effective framework for addressing problems that are identified. Thus, the monitoring and control mechanisms have been constantly improving over the years of the program operation.

3. **Several important improvements were introduced in both design and administration of the program over the years:** (a) an automatic benefit indexation mechanism was incorporated in 2019 (including the first ever 10 percent increase in the benefit); (b) establishing a network of regional service centers has been initiated, in the effort to provide better operational support to the district centers and jamoats in processing the TSA applications and responding to various inquiries; and (c) a large scale household survey implemented in 2016 informed improvements in the Proxy-Means-Test (PMT) formula.

4. **A key pending action of the Government is approval of the Decree on the TSA rollout in the remaining 28 districts.** When fully rolled out, the program is expected to cover about 200,000 of the households, or about 15 percent of the total number of households in the country, primarily focusing on those in extreme poverty.

5. **Pending national rollout, several adjustments in design of the program will be required in order to respond to specific risks and needs of the population.** While some improvements need to apply to the general design, it is also important to recognize that preparing the TSA as a mitigation mechanism goes beyond the original

objectives and design of the TSA program. Certain groups of the population may be hit particularly hard. For example, various shocks may have larger impacts on female-headed households, given their lack of income sources and limited coping mechanisms.

6. **Evaluation studies pointed to the need of greater involvement of local communities (mahalyas) in the Program's operation.** This could specifically improve the process of application facilitation and eligibility verification. Going beyond those functions would risk achievements gained to date.

7. **Introduction of differentiation in the benefit amount will be required**, since consumption depends on the size of the household and living conditions. While this dialogue has been initiated, no decision has been made as yet. A specific recommendation, in coordination with UNICEF, has been to link benefit level to number of children in the household. It has been indicated that this design change could be made budget neutral.

8. **To respond dynamically to various needs and shocks - in time and in space - a mechanism of periodic adjustments in the TSA threshold will be required.** At the moment, the eligibility threshold is quite static, which affects which families can be admitted and how effectively the budget of the program can be utilized, especially in the geographic dimension.

ANNEX 4: Rationale for nutrition-sensitive temporary social assistance to food-insecure households in Tajikistan

Key Messages:

- Past experiences suggest that the CoVid19 pandemic may cause substantial food price increases in Tajikistan. For example, during the 2014 Ebola outbreak, the affected countries recorded a short-term food price spike of 25%-30%.
- Tajikistan is particularly vulnerable to food price increases and already suffers from high food price volatility.
- A potential increase of 25% in food prices could increase the prevalence of stunting in the cohort of affected children by as much as 4.5 percentage point (from 17.4% to 22%), rolling back the progress seen in recent years (26% of children were stunted in 2012, DHS). This could jeopardize the human capital investments being made by the Government of Tajikistan and the WB.
- Nutrition-sensitive targeted cash transfers could substantially offset the impact of food price increases and reduce the risk of stunting among children living in the beneficiary households. It would also offer an additional opportunity to deliver messages on appropriate nutrition, hygiene, preventive health, and infection control to the beneficiaries.

1. Introduction:

This technical brief presents a rationale for including nutrition-sensitive targeted cash transfers in the proposed Tajikistan CoVid19 Emergency Project. The first section briefly discusses the risks of increases in potential food prices due to the CoVid19 pandemic. The second section presents the estimates of the impact of price increases on the risk of child stunting. The third section outlines the proposed nutrition-sensitive targeted cash transfer component to be included in the CoVid19 Emergency Project.

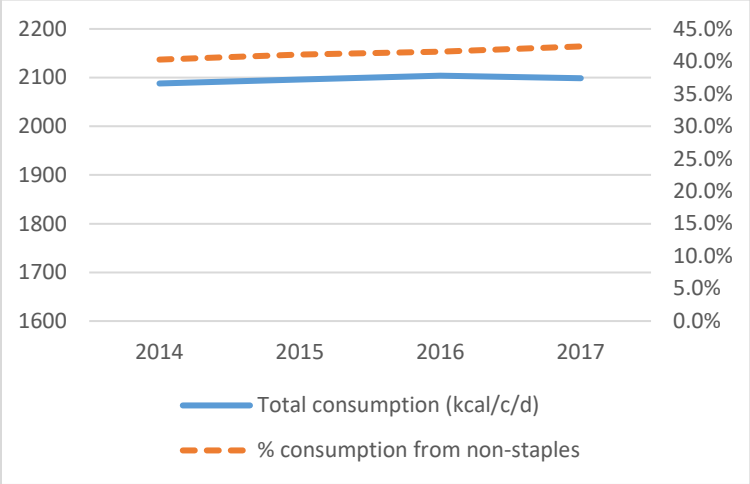
2. CoVid19 pandemic may lead to substantial increases in food prices:

Recent epidemic outbreaks have been associated with substantial price increase in low income countries. For example, during the 2014 Ebola outbreak, Liberia, Guinea, and Sierra Leone experienced short-term price increases of between 25% and 30% (WFP, 2014).

Due to very low domestic food production output and reliance on imports, Tajikistan is particularly vulnerable to food price increases due to exogenous shocks. The financial crisis of 2008, which resulted in dramatic decline of remittances and food price shocks, severely affected household income and food security in Tajikistan. Constant food price increases negatively affected the food diversity of the households as well as eating frequency, with an impact on the population's nutritional status, especially that of children.

According to the World Food Program (WFP) food price surveillance system, price increases in key food groups have already had a severe impact on the overall cost of the food basket in Tajikistan (WFP, 2020). Lower domestic production and restrictions in cross-border trade which resulting from the CoVid19 pandemic may lead to further food price increases.

Figure 1: Average Daily Caloric Intake and the Percentage of Total Calories from Non-Staple Foods in Tajikistan, 2014-2017.



Source: FAO Food Balance Sheets

Rising food prices may limit consumption, decrease dietary quality, and increase the risk of child stunting. The average caloric intake in Tajikistan is already low and stagnant around the minimum acceptable level of 2100 kcal per capita per day, there have been no noticeable improvements in dietary diversity (see Figure 1), and, according to the most recent estimates, 24% of households in the country are food insecure (WFP, 2018). Given this precarious situation, further food price shocks will likely include both decreasing the overall amount of food consumed (kcal per capita per day), pushing it below the minimum daily requirement, and decreasing the quality of the diet by forcing a substitution of more expensive and more nutritious foods (for example animal source protein such as dairy and meat products) with less expensive ones (staples such as cereals). Those negative coping strategies will, in turn, have an impact on nutrition status of the population overall, and young children in particular.

3. Rising food prices may significantly increase the risk of stunting and jeopardize the investments made by the Government and WB to improve human capital outcomes in Tajikistan:

We estimate that a spike of 25%, similar in magnitude to those recorded during the Ebola epidemic, could result in an average decrease of about 15% of kcal per capita per day consumed and about 18% decrease in dietary diversity, measured as calories from non-staple foods. Together, those decreases could lead to as much as a 4.6 percentage point increase in the prevalence of stunting (from 17.4%[8] to 22%) in the cohort of children exposed to the price increases.

This impact of rising food price on stunting prevalence was estimated by calculating the impact of price changes on food consumption (caloric intake and dietary diversity) and the impact of changes in consumption on stunting prevalence, using the following formula:

$S=P(C_{kcal}*E_{kcal}*B_{kcal}+C_{div}*E_{div}*B_{div})$

[8] Based on the stunting prevalence in children under 5 from Tajikistan DHS, 2017.

where:
S = change in stunting prevalence (in percentage points),
P = expected food price increase,
C_{kcal} = current food consumption, measured as kcal per capita per day,
C_{div} = current dietary diversity, measured as energy consumed from non-staples as % of total energy consumed,
E_{kcal} = price elasticity of demand for staples,
E_{div} = price elasticity of demand for non-staples,
B_{kcal} = marginal effect of the change in energy value of food consumed (in kcal per person per day) on stunting prevalence, in percentage points,
B_{div} = marginal effect of the change in dietary diversity (% of energy from non-staples) on stunting prevalence, in percentage points.

The baseline levels of consumptions were based on the most recent (2017) data form the FAO Food Balance Sheets: 2099 kcal per capita per day with 42.3% of energy consumed from non-staples. Increases in food prices were assumed to be 25% comparable to those recorded during the 2014 Ebola epidemic. Price elasticity of demand estimates for staples and non-staples were based on the recent systematic review and meta-analysis of own-price and cross-price elasticities by Cornelsen et al. (2015)[9]. For staples, the own-price elasticity was assumed to be -0.61 (own price elasticity for cereals in Cornelsen et al. 2015) and for non-staples -0.78 (own-price elasticity for meat and for dairy products, ibid.). The impact of the caloric intake and dietary diversity on stunting prevalence was estimated using the approach from Shekar, Kakietek, Dayton-Eberwein (2017), based on the parameter estimates from Haddad and Smith (2014), where one kcal decrease in the average calories consumed per capita per day was associated with 0.007 percentage point decrease in stunting prevalence and one percentage point decrease in the percent calories from non-staple foods was associated with 0.28 percentage point decrease in stunting prevalence.

4. **Nutrition-sensitive, targeted cash transfers can help offset the risk of stunting and losses to human capital.**

Empirical evidence shows that nutrition-sensitive cash transfers increase household food consumption, improve dietary diversity, and lead to better preventive health care seeking behaviors (Alderman, 2015). Therefore, they are a good strategy to protect the investment made in human capital from the negative impact of food price shocks.

Based on the most recent Household (Expenditure) Survey (2018), an average household in Tajikistan spends on food US $3050 per year, or about US $250 per month. A cash transfer targeting the most vulnerable households could substantially offset the impact of short-term increases in food prices. The transfers would also offer an opportunity to deliver messages on appropriate nutrition, hygiene, preventive health, and infection control to the beneficiaries.

The proposed unconditional cash transfer would be delivered monthly during a limited period of time to households affected by food price increases using the existing Targeted Social Assistance (TSA) program infrastructure and delivery mechanisms. The value and total duration of the transfers would be determined in

[9] The review by Cornelsen and colleagues focuses on low- and middle-income countries. Systematic reviews focused on high-income countries find similar ranges of elasticities (e.g. 0.60 for cereals, 0.65 for diary, 0.75 for beef in Andreyeva et al., 2010). Those are also consistent with modelling estimates for Tajikistan in Seale and colleagues (2003): own-price elasticity for bread and cereals 0.602 and .835 for meat and 0.987 for dairy.

consultation with the MOHSP the State Agency for Social Protection (SASP) and the key technical partners. The transfers would use a two-stage targeting mechanism. First, the transfers would target the oblast with high spikes in the prices of key food groups (wheat, milk and dairy, eggs). Food prices in each oblast would be monitored through the routine market monitoring systems of the Ministry of Economic Development and Trade used, among others, to calculate the CPI. A specific price increase threshold would be identified in consultation with the MOHSP, SASP, and key technical partners: WFP and UNICEF. When the threshold would be reached in an oblast, the nutrition-sensitive cash transfer program would be triggered in that in oblast. Once triggered, the program would target TSA beneficiary households with young children using an emergency cash assistance module. The TSA includes information on birth dates of all children in a household. These data are collected through a supplementary sheet to the main TSA application form, verified and confirmed by a community (jamoat) representative often along with supporting identification documents), and entered into the centralized database, which forms the National Social Registry with detailed information on each and every member of the household. This will enable targeting of the transfers to households with children under the age of 2, where the impact of a period of food insecurity on nutrition status and physical and cognitive development is much greater.

The proposed cash transfers would also provide an opportunity to use accompanying measure to promote optimal nutrition, appropriate hygiene, and preventive health services, as well CoVid19 infection prevention messaging. Those measures would include information delivered through mobile platforms (text messages, WhatsApp, Viber, etc.), printed media (posters in cash distribution sites), and interpersonal communication by community volunteers and jamoats. A communication campaign will be financed under Component 2 of the Tajikistan CoVid19 Emergency Project. The cash transfers would provide an important additional communication opportunity and, at the same time, make the cash transfers nutrition- and health-sensitive.

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ANNEX 5: Morbidity and Mortality Modelling

Crude Estimates of the Number of Severe and Critical Cases of COVID-19 Infection and COVID-19 Related Deaths, and the Potential Impact of Non-pharmaceutical Interventions.

Based on the data available today, depending on the prevalence of COVID-19 infection in Tajikistan, the disease may cause between 72,000 and 230,500 severe infections, between 13,600 and 43,500 critical infections requiring intensive care, and between 6,600 and 21,000 deaths (see Table 1).

Table 1: Estimated number of severe and critical cases of COVID-19 infection, and COVID-19-related deaths under different assumptions of the percentage of the population infected.

% of population infected with COVID-19	Number of severe cases	Number of critical cases	Number of deaths
25%	72,000	13,600	6,600
50%	144,100	27,200	13,100
80%	230,500	43,500	21,000

Non-pharmaceutical interventions including: 1.) isolating cases of COVID-19 at home, 2.) voluntary home quarantine, 3.) social distancing for the entire population, 4.) social distancing for the most vulnerable population – people over the age of 70, and 5.) closure of schools and universities, can limit the spread of the disease in the population (see Appendix for the description of the interventions). The most effective combination of those interventions: home isolation of COVID-19 cases, voluntary home quarantine, and social distancing of persons over the age of 70, has the potential to limit the spread of COVID-19 infection and reduce the number of critical cases and number of deaths by 49% (Ferguson et al., 2020). When applied to the estimates of potential morbidity and mortality in Tajikistan, this combination of interventions could avert between 3,200 and 10,300 deaths and between 6,600 and 21,300 of critical cases of COVID-19 infection (see Table 2).

Table 2: Number of critical infections and deaths averted by a combination of non-pharmaceutical interventions under different assumptions of the percentage of the population infected.

% of population infected with COVID-19	Number of critical infections averted	Number of deaths averted
25%	6,600	3,200
50%	13,300	6,400
80%	21,300	10,300

Methods and Data Sources

The impact of COVID-19 infection was calculated using age-specific estimates of case fatality and the prevalence of severe and critical cases from Ferguson et al. (2020). For each of the three scenarios, a different percentage of the population infected with the COVID-19 virus was assumed: 25% (Scenario 1), 50% (Scenario 2), and 80% (Scenario 3). The highest percentage is based on Ferguson et al. and assumptions made to model the impact of the non-pharmaceutical interventions in the US and the UK. The most recent age-specific estimates of the population of the Republic of Tajikistan (provided by the Tajikistan Statistical Office, TajStat), were multiplied by the percentage of the infected population to generate the number of age-specific infections in each scenario. Those, in turn, were multiplied by the age-specific estimates of the percentage of severe cases, critical cases, and by age-specific case-fatality ratios (all from Ferguson et al.).

Nd = $\sum_{i=1}^{n} Pi * CFR$i*I
Nsc = $\sum_{i=1}^{n} Pi * SC$i*I
Ncc = $\sum_{1=1}^{n} Pi * SCi * CC$i*I

Where:

Nd – number of deaths
Nsc – number of severe cases
Ncc – number of critical cases
P_i – age-specific population for age band i
I - percentage of the population infected
CFR_i - case fatality rate for age band i
Sc_i – percentage of infections that are severe (require hospitalization) for age band i
CC_i – percentage of severe cases that are critical for age band i

The estimates of case-fatality ratio, percentage of severe and critical cases in Ferguson et al. were based on Verity et al. (2020) estimates derived data form from China and adjusted to fit the UK population (for detail see Ferguson et al, 2020, Verity et al, 2020).

The impact of the non-pharmaceutical interventions on COVID-19-related mortality and morbidity is also estimated based on the modelling study by Ferguson et al (2020). The authors created a dynamic model of COVID-19 transmission (adapted from an earlier influenza model) and modelled the impact of different interventions that affected the transmission dynamics. The interventions and the assumptions used in the modelling of their impact are listed in Table 3. The authors modeled the potential impact of five different non-pharmaceutical interventions (NPI) implemented individually and in different combination and applied nationally for 3 months.

The impact estimates presented above are for the intervention combination that had the highest impact on mortality reduction: home isolation of COVID-19 cases, voluntary home quarantine, and social distancing of persons over the age of 70 (49% reduction in the number of deaths compared to no intervention). Given the fact that the impact of the interventions on mortality was due to the reduction in the number of COVID-19 infection (not to treatment effectiveness) we used the same impact estimate to model the reduction in the number of critical cases.

Table 3: Description of non-pharmaceutical interventions considered.

Intervention	Description and assumption
Case isolation in the home	Symptomatic cases stay at home for 7 days, reducing non-household contacts by 75% for this period. Household contacts remain unchanged. Assume 70% of household comply with the policy.
Voluntary home quarantine	Following identification of a symptomatic case in the household, all household members remain at home for 14 days. Household contact rates double during this quarantine period, contacts in the community reduce by 75%. Assume 50% of household comply with the policy.
Social distancing of those over 70 years of age	Reduce contacts by 50% in workplaces, increase household contacts by 25% and reduce other contacts by 75%. Assume 75% compliance with policy.
Social distancing of entire population	All households reduce contact outside household, school or workplace by 75%. School contact rates unchanged, workplace contact rates reduced by 25%. Household contact rates assumed to increase by 25%.
Closure of schools and universities	Closure of all schools, 25% of universities remain open. Household contact rates for student families increase by 50% during closure. Contacts in the community increase by 25% during closure.

The estimates presented above are generated for illustrative purposes only and should be not be considered as a valid projection of COVID-19-related mortality and morbidity in Tajikistan. As of the writing of this technical appendix, there are no reliable estimates of infection-fatality rate and the percentage of severe and critical cases for COVID-19 and the case-fatality rates reported in various populations in various reports vary widely (see e.g. Riou et al., 2020; Wilson et al., 2020; Mizumoto and Chowell, 2020; China CDC, 2020). Furthermore, the age-specific estimates for mortality and morbidity used were created by fitting data form China to the UK population and have not been adjusted to fit better the Tajik population profile. Finally, the impact of the interventions is estimated by a mathematical model and no reliable empirical data exists to validate the model's predictions.

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