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PROGRAM APPRAISAL DOCUMENT

ON A

PROPOSED CREDIT

IN THE AMOUNT OF SDR 145 MILLION

(US$200 MILLION EQUIVALENT)

TO THE

UNITED REPUBLIC OF TANZANIA

FOR THE

STRENGTHENING PRIMARY HEALTH CARE FOR RESULTS PROGRAM

May 6, 2015

Health, Nutrition and Population Global Practice
Eastern Africa Region Country Cluster 1
Africa Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective as of March 31, 2015)
Currency Unit = Tanzania Shilling (Tsh)
US$1.00 = Tsh 1,852
US$1.00 = SDR 0.7249

ABBREVIATIONS AND ACRONYMS

ANC	Antenatal Care
ANIS MDTF	Achieving Nutrition Impact at Scale Multi Donor Trust Fund
ARI	Acute Respiratory Infection
BOT	Bank of Tanzania
BP	Bank Policy
BEmONC	Basic Emergency Obstetric and Neonatal Care
BRN	Big Results Now
BSC	Balance Score Card
CAS	Country Assistance Strategy
CAG	Controller and Auditor General
CCHPs	Comprehensive Council Health Plans
CCT	Conditional Cash Transfer
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CHW	Community Health Worker
CHMT	Council Health Management Team
CRVS	Civil Registration and Vital Statistics
CSOs	Civil Society Organizations
CUIS	Common Used Items Systems
DALY	Disability-Adjusted Life Year
DED	District Executive Director
DFATD	The Canadian Department of Foreign Affairs Trade and Development
DHP	District Health Profile
DHIS	District Health Information System
DLIs	Disbursement-linked Indicators
DPs	Development Partners
DQA	Data Quality Audits
ESSA	Environmental and Social Management System Assessment
ESMF	Environmental and Social Management Framework
ESMP	Environmental and Social Management Plan
DQA	Data Quality Audits
F&C	Fraud and Corruption
FSA	Fiduciary Systems Assessment
GAC	Governance and Anti-Corruption
GDP	Gross Domestic Progress
GFF	Global Financing Facility
GoT	Government of Tanzania
GPSA	Government Procurement Services Agency
GRS	Grievance Redress Service
HBF	Health Basket Fund
HBS	Household Budget Survey
HCWM	Health Care Waste Management
HFs	Health Facilities

HFGCs	Health Facility Governing Committees
HMIS	Health Information System
HRH	Human Resources for Health
HRHIS	Human Resource for Health Information System
HRITF	Health Results Innovation Trust Fund
HSSP	Health Sector Strategic Plan
IAG	Internal Auditor General
ICT	Information and Communication Technology
IDA	International Development Association
IPT	Intermittent Preventive Treatment
IFMIS	Integrated Financial Management Information System
IHME	Institute for Health Metrics and Evaluation
IMCI	Integrated Management of Childhood Illness
IRR	Internal Rate of Return
INT	Institutional Integrity
ITN	Insecticide – Treated Net
JAHSR	Joint Annual Health Sector Review
LAAM	Local Authority Accounting Manual
LAAC	Local Authority Accounts Committee
LAFM	Local Authority Financial Memorandum
LGAs	Local Government Authorities
LMIC	Low & Middle Income Countries
LMIS	Logistic Management Information System
MDA	Ministries, Departments and Agencies
MDG	Millennium Development Goals
MDU	Ministerial Delivery Unit
MFL	Master Facility List
M&E	Monitoring and Evaluation
MKUKUTA	National Strategy for Growth and Poverty Reduction
MMR	Maternal Mortality Ratio
MNCH	Maternal, Neonatal, and Child Health
MOF	Ministry of Finance
MOHSW	Ministry of Health and Social Welfare
MOU	Memorandum of Understanding
MSD	Medical Store Department
MTR	Mid-term Review
NCB	National Competitive Bidding
NHIF	National Health Insurance Fund
NKRA	National Key Results Area
NPV	Net Present Value
OC	Other Charges
OECD	Organization for Economic Cooperation and Development
OP	Operational Policy
OPD	Outpatient Department
PAC	Public Accounts Committee
PCCA	Prevention and Combating of Corruption Act
PCCB	The Prevention and Combat of Corruption Bureau
PDB	President's Delivery Bureau
PDO	Project Development Objectives
PE	Personnel Emoluments
PEFA	Public Expenditure and Financial Accountability

PFM	Public Financial Management
PforR	Program for Results
PHC	Primary Health Care
PI	Performance Indicators
PMO-RALG	Prime Minister's Office – Regional Administration and Local Government
PMTCT	Protection of Mother to Child Transmission
PMU	Procurement Management Unit
POM	Program Operational Manual
POPSM	Presidents' Office Public Service Management
PPA	Public Procurement Act
PPAA	Public Procurement Appeal Authority
PPP	Public Private Partnership
PPRA	Public Procurement Regulatory Authority
PSSN	Productive Social Safety Net
RAS	Regional Administrative Secretariat
RBF	Results-based Financing
RHMT	Regional Health Management Team
RITA	Registration Insolvency and Trusteeship Agency
RMNCAH	Reproductive, Maternal, Neonatal, Child and Adolescent Health
SARA	Service Availability and Readiness Assessment
SBUs	Special Business Units
SDI	Service Delivery Indicators
SDR	Special Drawing Rights
TDHS	Tanzania Demographic Health Survey
TA	Technical Assistant
TB	Tender Boards
TFDA	Tanzania Food and Drugs Authority
TFR	Total Fertility Rate
TIIS	Training Institute Information System
UNICEF	United Nations Children's Fund
US$	United States Dollars
USAID	United States Agency for International Development
WDI	World Development Indicator
WGI	World Governance Indicators
WHO	World Health Organization
YLL	Years of Life Lost

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UNITED REPUBLIC OF TANZANIA

STRENGTHENING PRIMARY HEALTH CARE FOR RESULTS PROGRAM

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PAD DATA SHEET

United Republic of Tanzania

Strengthening Primary Health Care For Results Program

PROGRAM APPRAISAL DOCUMENT

Africa Region

Basic Information				
Date:	May 6, 2015		Sectors:	Health (100%)
Country Director	Philippe Dongier		Themes	Child Health (25%); Health System Performance (35%); Nutrition and Food Security (15%); Population and Reproductive Health (25%)
Practice Manager/Senior Global Practice Director:	Abdo Yazbeck / Timothy G. Evans			
Program ID:	P152736			
Team Leader(s):	Rekha Menon and Son Nam Nguyen			
Program Implementation Period:	Start Date:	May 27, 2015	End Date:	June 30, 2020
Expected Financing Effectiveness Date:	August 25, 2015			
Expected Financing Closing Date:	June 30, 2020			

Program Financing Data			
[ ] Loan [X] Grant [X] Other [X] Credit			
For Loans/Credits/Others (US$M):			
Total Program Cost :	2,620 M	Total Bank Financing :	200 M (IDA)
Total Cofinancing:	2,420 M (including Global Financing Facility; Achieving Nutrition Impact at Scale Multi Donor Trust Fund; United States Agency for International Development Trust Fund)	Financing Gap :	0

.

Financing Source	**Amount**
BORROWER/RECIPIENT	2,030 M
IBRD/IDA	200 M
Global Financing Facility (GFF)	40 M
USAID Trust Fund	40 M
ANIS MD Trust Fund	20 M
Other Partners	290 M
Total	2,620 M

.

Borrower: United Republic of Tanzania

Responsible Agency: Ministry of Health and Social Welfare

Contact:	Dr. Donan Mmbando	Title:	Permanent Secretary
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Responsible Agency: Prime Minister’s Office, Regional Administration and Local Government

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Expected Disbursements (in USD Million)

Fiscal Year	FY16	FY17	FY18	FY19	FY20
Annual	20.5	47.5	44.0	44.0	44.0
Cumulative	20.5	68.0	112.0	156.0	200.0

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Program Development Objective(s)

The Program Development Objective is to improve the quality of primary health care (PHC) services nation-wide with a focus on maternal, neonatal, and child health (MNCH) services.

Compliance

Policy

Does the program depart from the CAS in content or in other significant respects?	Yes	[ ]	No	[X]

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Does the program require any waivers of Bank policies applicable to Program-for-Results operations?	Yes	[ ]	No	[X]
Have these been approved by Bank management?	Yes	[ ]	No	[ ]
Is approval for any policy waiver sought from the Board?	Yes	[ ]	No	[X]
Does the program meet the Regional criteria for readiness for implementation?	Yes	[X]	No	[ ]

Overall Risk Rating: Substantial

Legal Covenants

Name	Recurrent	Due Date	Frequency
The Recipient shall adopt a Program operational manual consisting of the RBF Operations Manual and the HBF Memorandum of Understanding both in form and substance satisfactory to the Association.		Three months after effectiveness	
The Recipient shall carry out under terms of reference satisfactory to the Association in each Fiscal Year beginning FY2016 an audit of contracts procured in the preceding FY and furnish said audit to the Association.	Yes	No later than six months after the end of each FY	Each year
The Recipient shall carry out a Value for Money Audit.		(i) during the mid-term review and (ii) no later than	Twice during program implementation.

		six months prior to the closing date.	
Description of Covenant			
.			
Team Composition			
Bank Staff			
Name	**Title**	**Specialization**	**Unit**
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Michael Okuny	Sr. Financial Management Specialist	Financial Management	GGODR
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I. STRATEGIC CONTEXT

A. Country Context

1. Tanzania's gross domestic product (GDP) growth has remained stable at around 7 percent over the past decade thanks to increased private consumption and public investment, together with rapidly expanding sectors such as communication, construction, financial services, and mining. Inflation declined from over 19.0 percent in 2011 to 5.9 percent in 2014 thanks to tight monetary policy and falling international energy and food prices. However, fiscal space has been reduced during the past four years as a result of lower-than-expected domestic revenue collection, diminishing aid disbursements, and higher investment in infrastructure projects.

2. Notwithstanding strong and stable economic growth, poverty has only decreased marginally from 34 percent in 2007 to 28 percent in 2012. In addition, 44 percent of the population lives on less than US$1.25 per day and 90 percent of the population lives on less than US$3 per day. Low elasticity of growth on poverty reduction is explained by: (i) slower than expected improved human capital stock on income generation opportunities; and (ii) a lack of growth in labor intensive sectors, including agriculture in rural areas (where 84 percent of poor households reside) and in manufacturing.

3. In 2000, Tanzania adopted the Tanzania Development Vision 2025 with the aim to build a society characterized by: (i) quality livelihoods; (ii) peace, stability and harmony; (iii) good governance and rule of law; (iv) an educated and learning population; and (v) a vibrant and competitive economy by 2025. Tanzania's National Strategy for Growth and Poverty Reduction (MKUKUTA II 2010 –2015) has three priorities: (i) growth and reduction of income poverty; (ii) improvement of quality of life and social well-being; and (iii) good governance and accountability. It explicitly identifies improvements in human resources for health (HRH), maternal health, health facilities and service delivery as national priorities.

B. Sectoral and Institutional Context

4. **Over the last 10 years, Tanzania has successfully reduced death rates in younger age groups and surpassed the Millennium Development Goal (MDG) related to child mortality**. Between 1999 and 2010, infant mortality fell from 99 to 51 per 1,000 live births, while under-five mortality declined from 147 to 81 per 1,000 live births[1]. A 2008 Lancet article on child survival gains in Tanzania[2] attributed a large proportion of these improvements to investments in health systems and scaling up specific interventions through a decentralized approach. These include improvements in (i) the share of children under five sleeping under bed nets (from 36.3 percent in 2007/8 to 72.6 percent in 2009/10); (ii) full coverage of vaccination and vitamin A supplements; and (iii) the functioning of Integrated Management of Childhood Illness (IMCI) at health facility and community levels.

5. **Despite such progress, Tanzania's health outcomes are still lower than expected for its level of economic development** (Table 1). Communicable diseases remain the major burden

[1] Tanzania Demographic and Health Survey (TDHS), 2010.
[2] Masanja, H., et al, *Child Survival Gains in Tanzania: Analysis of Data from Demographic and Health Surveys*, The Lancet, 2008; 371: 1276–83.

Table 1: Benchmarking of Tanzania's Health Outcomes and Expenditures against 14 Comparator Countries[3]

Indicator	Tanzania's rank
Economic Development	
GDP per capita	8
Health outcomes	
Age-standardized death rate	6
Maternal mortality ratio	12
Life expectancy at birth	8
Health-adjusted life expectancy at birth	8
Neonatal mortality rates	2
Stunting (children < 5 years)	15
Health expenditures	
Health expenditure per capita, PPP	2
Total health expenditures as % of GDP	3
Public expenditure on health as % of GDP	3
Public expenditures on health as % of government budget	8

Source: IHME 2013 and WDI 2013

of mortality and morbidity for the population. Progress in reducing maternal mortality and neonatal mortality has been slow. Maternal mortality ratio remains high at 432 deaths per 100,000 live births in 2012 against a backdrop of low coverage of facility deliveries and family planning. While the neonatal mortality rate is lower than in comparator countries at the same level of economic development, it is still high at 26 per 1,000 live births.[4] Stunting is persistently high (42 percent among children under five years of age), affecting over 3 million children (Table 2).

6. Physical access to health services has significantly improved in Tanzania with the construction and renovation of PHC facilities in rural areas. Most people are living within 5 to 10 km from a clinic.[5] On the demand side, there have been various initiatives to: (i) provide cash transfers to extremely poor households conditional on their utilization of health services; and (ii) enroll such poor households in Community Health Funds to provide financial protection.

Table 2: Tanzania's Health Outcomes and Health Expenditures

	Tanzania[1]		Sub-Saharan Africa[2]
Outcome Indicators	**2005**	**2010**	**2013**
Under 5 mortality rate per 1,000 live births	112	45[3]	92.4
Infant mortality rate per 1,000 live births	68	51	61
Maternal mortality ratio per 100,000 live births	578	432[3]	510
Total Fertility Rate (Children per Woman)	5.7	5.2[3]	5.1
Stunting (Height for Age <-2SD, %)	38	42	37
Underweight (Weight for Age <-2SD, %)	22	16	21
Wasting (Weight for Height <-2SD, %)	3	5	9
Service Coverage Indicators			

[3] Comparators are 14 countries close to Tanzania in the global ranking of economic development (7 immediately above and 7 immediately below). In the ranking, 1 indicates the best rank, 15 the worst. For Tanzania, a rank above 8 means better performance than expected at the country's level of development.
[4] Ibid.
[5] *Tanzania Demographic and Health Survey 2007*. Dar es Salaam: Bureau of Statistics Planning Commission of Tanzania; 2007.

Skilled birth attendance (% of pregnant women)	47	51	50
Contraceptive prevalence rate (% of women ages 15-49 years)	20	27	24
Full immunization coverage (% of children aged 12-23 months)	71	75	n.a.
Children who slept under an ITN last night (% of under-5 children)	16	64	35.2
Women who slept under an ITN last night (% of pregnant women)	16	57	n.a.
Health Financing Indicators[3,4]			
Total expenditure on health per capita	11.9	41.3	96.2
Total public expenditure on health per capita	5.9	16.3	n.a.
Share of health in the government budget	10.3	8.7	n.a.

[1]Data of MMR, TFR, nutritional and service coverage indicators are for years 2005 and 2010 ;
[2]Nutrition indicators are for Sub-Saharan African developing countries' average only, while others are for the whole regional average;
[3] 2012 Census data
[4]All health financing indicators listed under "2010" indicate latest year data;
[5]All per capita expenditure data are in the unit of current US$ (i.e. at exchange rate rather than purchasing power parity).
Source: DHS, Census 2012, World Development Indicators and WHO data.

7. **Low quality of care remains a major bottleneck.** In many cases, low quality of care reduces utilization of services. There is evidence that community perceptions of the quality of local health facilities influence women's decisions to deliver in a clinic.[6] An example of low quality of care is facilities' poor compliance with service standards for basic and comprehensive emergency obstetric and neonatal care (BEmNOC and CEmNOC). According to the 2012 Service Availability and Readiness Assessment (SARA), only 32.3% of dispensaries and 50% of health centers had the capacity to provide BEmNOC services. Among all hospitals, around 73% met CEmNOC service standards.

8. **On the supply side, a range of serious challenges contribute to low quality of care and poor health outcomes**:

- **Tanzania spends significantly less public money on health than comparable countries.** Health financing is highly dependent on external support (which accounted for 48 percent of total public expenditure on health in 2011/12) which is fragmented and mostly off-budget. Public expenditure on health has been flat in real terms, while the share of health in the Government's budget has declined from 11.9 percent in 2010/11 to 8.7 percent in 2013/14.

- **Service delivery is constrained by both a shortage and inequitable distribution of skilled human resources for health (HRH)**. Nation-wide, there are 554 dispensaries without skilled health workers. Instead, they are staffed by medical attendants who are not

[6] Kruk ME, Rockers PC, Mbaruku G, Paczkowski MM, and Galea S. *Community and Health System Factors Associated with Facility Delivery in Rural Tanzania: a Multilevel Analysis*. Health Policy. October 2010.

qualified to manage patients by themselves. The national average ratio of clinicians and nurses per 10,000 population is low at 7.7, which is only one third of the WHO recommended number of 22.8. While Dar es Salaam represents just 10 percent of Tanzania's population as per the latest census, it is home to as many as 45 percent of the country's doctors[7] and 20 percent of its health personnel. On the contrary, rural areas have only 9.1 percent of the doctors and 28 percent of the health workforce.

- **Decentralization in the health sector has not fully materialized, hindering the operations of facilities**. Health facilities have limited financial autonomy to utilize their own funds. Until recently[8], most primary health care (PHC) facilities did not even have a bank account. Funding for PHC was channeled to local government authorities (LGAs) which often serve as a major bottleneck preventing resources to reach lower levels.

- **Accountability for results is low at all levels**, especially between (i) central government and LGAs, (ii) LGAs and facilities and (iii) facilities and communities. As a result, more than half of health workers are either absent or late during work hours. According to the 2014 Service Delivery Indicators (SDI) survey, on average, 14.3 percent of health providers were absent from the facilities. Absenteeism was more prevalent in Dar es Salaam where 1 out of 5 health workers were not found in their work place. Doctors, especially those in urban areas, are the most likely to be absent, often without permission. Adherence to good clinical practices is poor. A review of clinicians' ability to manage maternal and neonatal complications in the same survey showed only a 30.4 percent compliance rate with clinical guidelines among providers. This rate is somewhat higher among doctors (35.7 percent). There was no significant difference in the performance of public and private (for and not-for-profit) providers. Furthermore, essential drugs are frequently out of stock, and facilities are in poor conditions.

- **There has been limited progress in engaging the private health sector through public private partnerships (PPPs)**.

9. The Mid-term Review (MTR) for the Health Sector Strategic Plan (HSSP) III FY09-FY15 concluded that the health sector is making progress in all strategic areas, but the overall pace is slower than anticipated; there is progress in systems development (policies, strategies, guidelines, work plans, etc.) than in service delivery.[9] Innovations are only slowly trickling down to front line health facilities. Vertical disease control programs are performing better than either general or reproductive health services. Low attendance rates of outpatient departments and maternity wards can be an indication of the population's dissatisfaction with health services. The MTR suggested that for the coming years, the focus should be on: (i) improving value for money by making optimal use of available resources for better quality; and (ii) increasing transparency and accountability for results (including community engagement). The MTR also emphasized the need to improve health

[7] This does not include higher level hospitals which are concentrated in Dar es Salaam and are the facilities that have the highest number of doctors.
[8] PMORALG has recently directed councils to open bank accounts for all health facilities.
[9] Tanzania Ministry of Health and Social Welfare, *Health Sector Strategic Plan III, "Partnerships for Delivering the MDGs", July 2009 – June 2015, Mid Term Review*, October 2013.

outcomes through sustainable service delivery systems and pointed out that harmonization of processes is not an end in itself.

10. To address the health system challenges identified by the MTR, the Government has recently embarked on a high profile initiative called Big Results Now in Health (BRN in Health) 2015-2018 with the aim to accelerate the reduction of maternal and neonatal mortality through improving performance, governance and accountability in primary health care (PHC). BRN in Health is embedded in the medium-term Fourth Health Sector Strategic Plan (HSSP IV) which guides health sector development in Tanzania over the next 5 years (FY16-FY20).

C. Relationship to the CAS/CPS and Rationale for Use of Instrument

11. The Tanzania Country Assistance Strategy (CAS) FY2012-15 [10] is aligned with the priorities in the government's MKUKUTA II 2010/11 – 2014/15 and the World Bank's Africa Strategy (2011). Consistent with MKUKUTA II, the World Bank's Africa Strategy has two broad pillars: (i) competiveness and employment, addressing poor business environment, poor infrastructure, and the need for a healthy and skilled workforce; and (ii) vulnerability and resilience, addressing the high risk of idiosyncratic shocks, including those to individuals' health (HIV/AIDS, malaria, ebola, maternal mortality, etc.). Governance and public sector capacity is a foundation of the Africa Strategy.

12. The proposed operation is fully aligned with two of the four objectives set out in the CAS: (i) strengthening human capital and safety nets, which aims to improve, *inter alia*, access to and quality of health service; and (ii) promoting accountability and governance, which is a cross-cutting objective to improve accountability and efficiency of public management. The CAS also commits to addressing gender concerns and includes specific interventions to address gender inequalities in various sectors; the very high maternal mortality rates is one of the critical issues highlighted for attention. Specific health indicators under the CAS include reducing overall maternal mortality rates and increasing the proportion of births attended by skilled health personnel. With a focus on maternal health, this operation will help turn such gender commitments into actions and results.

13. The June 2014 CAS Progress Report (80313-TZ) restates the relevance of the CAS, but includes adjustments to not only reflect recent developments in Tanzania and the government's evolving priorities, but also to align with the World Bank Group's twin goals of ending poverty and boosting shared prosperity. Such adjustments are organized around two clusters, of which the proposed operation falls under the cluster of programs to reduce extreme poverty and improve quality of social services. The Progress Report also promotes the use of performance-based instruments such as Program for Results (PforR) to facilitate the achievement of results. Finally, as the poor in Tanzania suffer from a higher burden of disease and the impoverishment effects of out-of-pocket payments for care, the proposed operation will contribute to the World Bank's twin goals of poverty reduction and shared prosperity by improving health outcomes for the poor.

[10] The June 2014 CAS Progress Report proposed a 12 month extension to the CAS, until 2016.

14. PforR is the most suitable Bank instrument to support the proposed operation for the following reasons:

- It promotes a focus towards policies and sector results, moving away from specific inputs found in traditional sector investment or operations.
- The Government of Tanzania is committed to results in the health sector as shown in the Big Results Now (BRN) in their health plan. The PforR approach would be aligned with this commitment.
- It allows the Bank to effectively harmonize its support with funding from the government and other DPs, increasing the leverage of Bank's resources.
- It makes the Bank's contribution more flexible and responsive to country's needs with the provision of non-earmarked funds.
- It supports the governments' own agenda using country systems with due attention to systems strengthening, which will enhance development impact and sustainability.
- It motivates country implementers to find locally relevant and sustainable solutions to overcome operational bottlenecks to the achievement of results.
- Tanzania already has experiences with the PforR instrument with two projects (one in urban sector and one in education).

15. The PforR approach also provides a performance-based framework for other development partners to align their support to the government in health. Other development partners contributing to the health basket fund (the pooled funding mechanism to support the operating cost of PHC in the country) will also adopt the several of the DLIs under this proposed PforR for their own disbursements to the GoT. Through this approach, the operation will therefore: (i) continue and enhance development partner coordination in the pooled funding mechanism; (ii) increase the leverage of IDA funding; and (iii) help other development partners apply the PforR approach to their own assistance for health in Tanzania.

16. Tanzania is also proposed to be a front-runner country for the Global Financing Facility (GFF) with a GFF grant of US$40 million. Built on the successes of the Health Results Innovation Trust Fund (HRITF), GFF is a new multi-donor trust fund to support (i) reproductive, maternal, neonatal, child and adolescent health (RMNCAH) and (ii) civil registration and vital statistics (CRVS). This PforR aligns closely with the main objectives of the GFF to: (i) finance national RMNCAH scale-up plans for results; (ii) support countries in the transition toward sustainable domestic financing of RMNCAH; and (iii) contribute to a better-coordinated and streamlined RMNCAH financing architecture. In addition, Tanzania is also a front-runner country for the Achieving Nutrition Impact at Scale Multi-donor Trust Fund (ANIS MDTF) with a grant of US$20 million aimed at scaling up and institutionalizing nutrition interventions.

II. PROGRAM DESCRIPTION

A. Program Scope

17. This PforR operation will support the government's primary health care (PHC) program for the 2015/16 – 2019/20 period, with a strong focus on a key government initiative, the Big Results Now in Health (BRN in Health).

18. **PHC under the Health Sector Strategic Plan IV (including BRN in Health) constitutes the Government's program.** In the structure of Tanzania's health system, PHC is delivered at the district level and below, involving district hospitals, health centers, dispensaries and community-based health services under the management of Council Health Management Teams (CHMTs). Over the next five years, major reforms and implementation of PHC will be guided by HSSP IV.

19. The 2015-2018 BRN in Health program aims to accelerate the reduction of maternal and neonatal mortality through improving performance, governance and accountability in PHC. It was developed as part of Tanzania's Development Vision 2025 and has four national key results areas (NKRAs) which are the following:

(i) *Performance Management*: This result area aims to improve health workers' performance. Interventions include: (i) a stepwise accreditation scheme for all PHC facilities in the country (aka "Star Rating" initiative) which has both nation-wide assessment and a subsequent facility improvement program (including RBF incentives) to help facilities improve their performances and star ratings; (ii) implementation of the Decentralization by Devolution Policy by empowering health facilities to plan; budget and manage revenue in line with the Health Cost Sharing Guidelines; (iii) performance contracts and targets at individual health worker levels; and (iv) social accountability mechanisms.

(ii) *Human Resources for Health*: This result area aims to improve the distribution of skilled PHC workers especially in nine regions with critical shortages in human resources for health (i.e. less than national averages). Interventions include: (i) increasing PHC employment permits for such regions; (ii) engaging the private sector to provide skilled HRH for public health facilities through PPPs; (iii) redistributing health care workers within regions; and (iv) optimizing the pool of new recruits through "bonding" policy or compulsory attachments.

(iii) *Health Commodities*: This result area aims to improve the availability of essential medicines in PHC facilities. Interventions tackle key issues along the health commodities supply chain and include: (i) introducing new governance and accountability mechanisms; (ii) developing a new finance and business model for Medical Stores Department (MSD); (iii) engaging private sector in procurement and distribution; (iv) implementing quality improvement initiatives for inventory management; and (v) using innovative information and communication technology (ICT) to report stock-outs.

(iv) *Maternal, Neonatal and Child Health*: This result area aims to improve the coverage and quality of MNCH along the continuum of care. Interventions include: (i) ensuring the dispensaries and health centers meet basic emergency obstetric and neonatal care (BEmONC) requirements; (ii) expanding comprehensive emergency obstetric and neonatal care (CEmONC) to selected hospitals and health centers; (iii) strengthening the corresponding satellite blood banks which serve facilities with CEmONC; and (iv) extending MNCH services to communities through the use of community health workers (CHWs) and awareness campaigns. Five regions that are poorly performing on maternal and neonatal mortality indicators will receive priority focus.

20. As a GFF front-runner country, the Government of Tanzania is developing a RMNACH investment case in line with its existing strategies and policies; namely BRN in Health, the Sharpened One Plan II (the national strategy to accelerate reduction of maternal, newborn and child deaths) and HSSP IV which were developed in a consultative and evidence-based manner. With a long term vision for RMNACH, this investment case identifies priorities for scaling up investments to accelerate the achievements of RMNACH goals. It also builds on the CRVS Strategy and the Health Financing Strategy. These two strategies are in an advanced stage of finalization and their endorsements by the Parliament are expected soon. As part of its development, extensive consultations with development partners, civil society and private sector have been conducted. This program supports the operationalization of this investment case as a critical step towards the realization of the GFF vision to end preventable maternal, newborn, child and adolescent deaths in Tanzania.

21. A core objective of the GFF is to support countries to harmonize RMNCAH financing and to move towards sustainability by harnessing domestic resources. In the case of Tanzania, the draft Health Financing Strategy encompasses several key strategies to realize the above vision, namely: (i) creating fiscal space through efficiencies; (ii) better defining functions of key actors in the sector including purchasers and providers of health services; and (iii) improving value for money with a pay-for-quality element in the planned capitation payment for PHC. The proposed program supports the government to operationalize such strategies and includes targets for improvements in (i) domestic financing for health; (ii) the capacity of institutions involved in purchasing and provision; and (iii) value for money through the introduction and scale-up of performance-based financing at various levels.

22. HSSP IV and the Government's draft Health Financing Strategy also incorporate the results-based financing (RBF) approach for PHC facilities. This scheme provides quarterly incentive payment to PHC facilities according to their levels of achievement of a set of performance indicators which are independently verified. RBF design is informed by a pilot conducted in Pwani region with support from the government of Norway. An independent impact evaluation of the pilot (conducted between 2011 and 2013) showed promising results, with significant positive effects on a range of incentivized services. On the basis of the evaluation and lessons from other countries, the RBF design includes system strengthening measures and broadens the scope of the scheme to include quality of care measures and the use of CHWs to improve the continuum of RMNCAH care.

23. Planned to be rolled out in a phased manner as part of HSSP IV, the RBF aims to enhance provider accountability for results and encompasses broader health system strengthening measures through incentivizing facilities for improved accountability, governance, management and quality of PHC services at dispensaries, health centers and district hospitals. Phase 1 of the RBF roll-out will cover at least 7 regions by 2020.

24. As nutrition is a multi-sectoral issue, the integration of relevant nutrition interventions in RMNCAH services can achieve better outcomes (for both nutrition and health). The proposed operation will address key bottlenecks in service delivery including those essential to a large scale nutrition action (i.e., human resources, commodity procurement, etc.). Delivering nutrition interventions as part of the routine MNCH services would contribute to the sustainability of the nutrition program in Tanzania.

25. **The entire PHC component (including BRN in Health) in HSSP IV constitutes the program which the operation supports**. The total cost of the program is estimated at US$2.62 billion or 55 percent of the GOT's health sector budget over the next five years, of which US$300 million (11.5 percent of the total program cost) will be financed under the proposed PforR. Funding for the program includes: (i) US$200 million in IDA credit; (ii) US$40 million in GFF grant; (iii) US$20 million in ANIS MDTF Grant; and (iv) a US$40 million in grant from USAID through a single-donor trust fund arrangement.[11] Other development partners are expected to contribute US$290 million (or 11.1 percent) through parallel financing. The GOT will finance the remaining balance, or 77.5 percent of the program cost. Program scope and funding requirements are summarized in Table 3.

Table 3: Expenditure Requirements

PHC Initiatives	Planned Expenditures in US$					Total	Percent
	2015/16	2016/17	2017/18	2018/19	2019/20		
Personnel Emoluments	237,771,583	264,424,761	274,295,978	284,937,436	296,237,362	1,357,667,120	50.8%
Non-salary recurrent							
Other Charges (block grant)	37,141,442	39,447,427	41,782,912	44,269,303	46,917,025	209,558,110	7.8%
Other non-salary recurrent (HBF)	55,000,000	55,000,000	55,000,000	55,000,000	55,000,000	275,000,000	10.3%
Medicines	106,630,991	109,772,467	112,904,418	116,178,647	119,547,827	565,034,350	21.2%
Infrastructure	2,241,776	2,313,858	2,381,779	2,452,393	2,525,820	11,915,626	0.4%
BRN in Health							
Human Resources in Health	2,337,389	3,238,142	2,927,303			8,502,834	0.3%
Performance Management							
Accreditation, Social Accountability and Fiscal Decentralization	5,710,588	4,117,600	4,778,342			14,606,530	0.5%
Facility Based Incentives (RBF)	3,500,000	20,000,000	25,000,000	25,000,000	25,000,000	98,500,000	3.7%
Health Commodities	8,027,370	4,118,244	4,749,209			16,894,823	0.6%
MNCH	29,039,743	17,199,695	16,159,495			62,398,933	2.3%
	487,400,882	***519,632,195***	***539,979,436***	***527,837,779***	***545,228,035***	***2,620,078,326***	*100.0%*

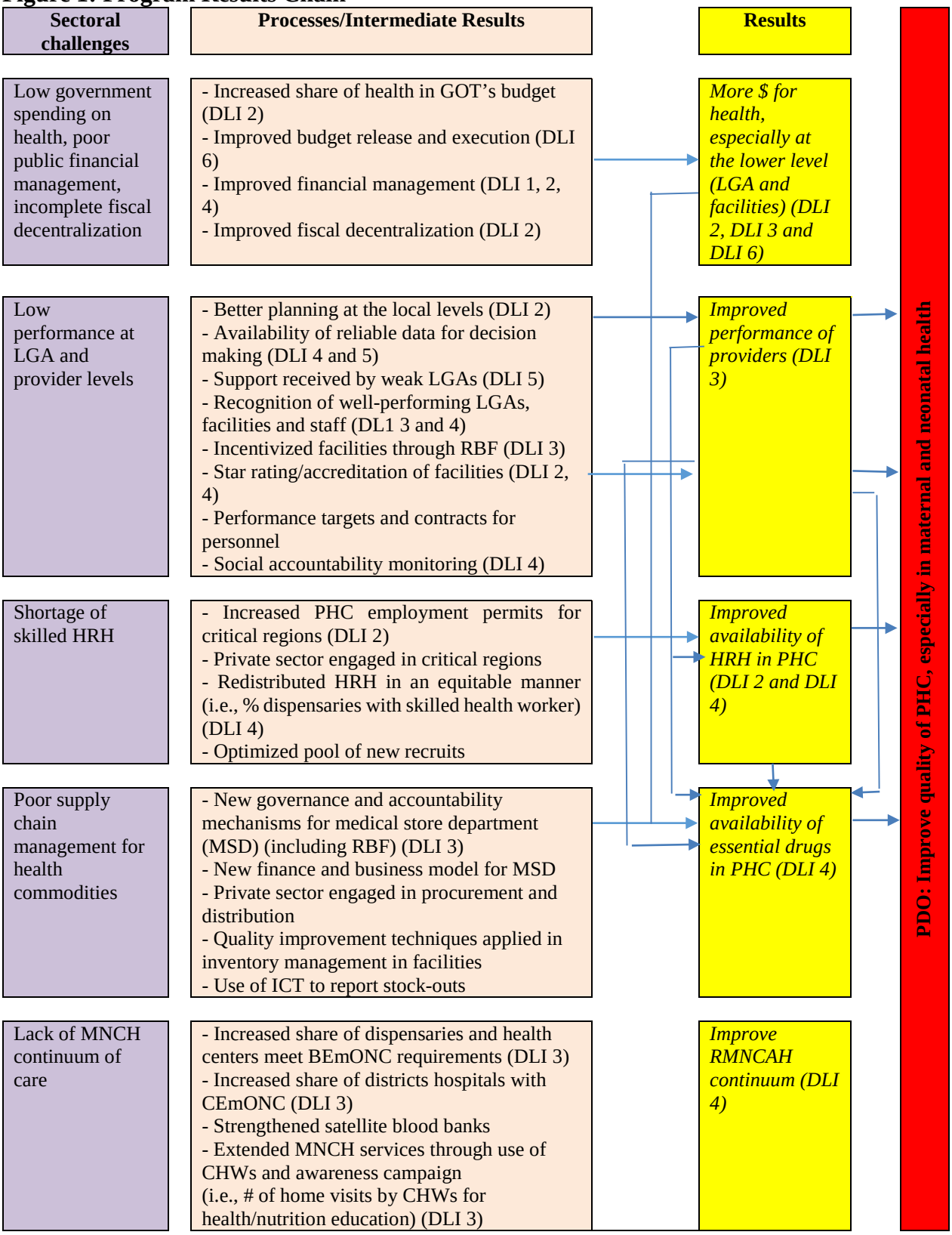
Source: Budget data projections and BRN in Health costing data.

26. **The scope of the proposed program includes recurrent and operating costs, goods, small works and services.** However, it excludes high-risk activities, defined as those that: (i) are judged to be likely to have significant adverse impacts that are sensitive, diverse, or unprecedented on the environment and/or affected the population; and/or (ii) involve procurement of goods, works, and services under high-value contracts.

27. The results chain of the program is illustrated in Figure 1.

[11] The estimated amount of the USAID Trust Fund is US$40 million.

Figure 1: Program Results Chain



B. Program Development Objective

28. The program development objective is to improve the quality of primary health care (PHC) services nation-wide with a focus on maternal, neonatal and child health (MNCH) services.

C. Program Key Results and Disbursement Linked Indicators

29. Key program results indicators include:

i. Percentage of PHC facilities with 3-star rating and above;[12]
ii. Percentage of antenatal care (ANC) attendees receiving at least two doses of intermittent preventive treatment (IPT2) for malaria;
iii. Percentage of institutional deliveries;
iv. Percentage of expected pregnant women attending four or more ANC visits;
v. Percentage of children 12-59 months of age receiving vitamin A supplementation; and,
vi. Percentage of dispensaries with skilled HRH (at least a clinician or nurse).

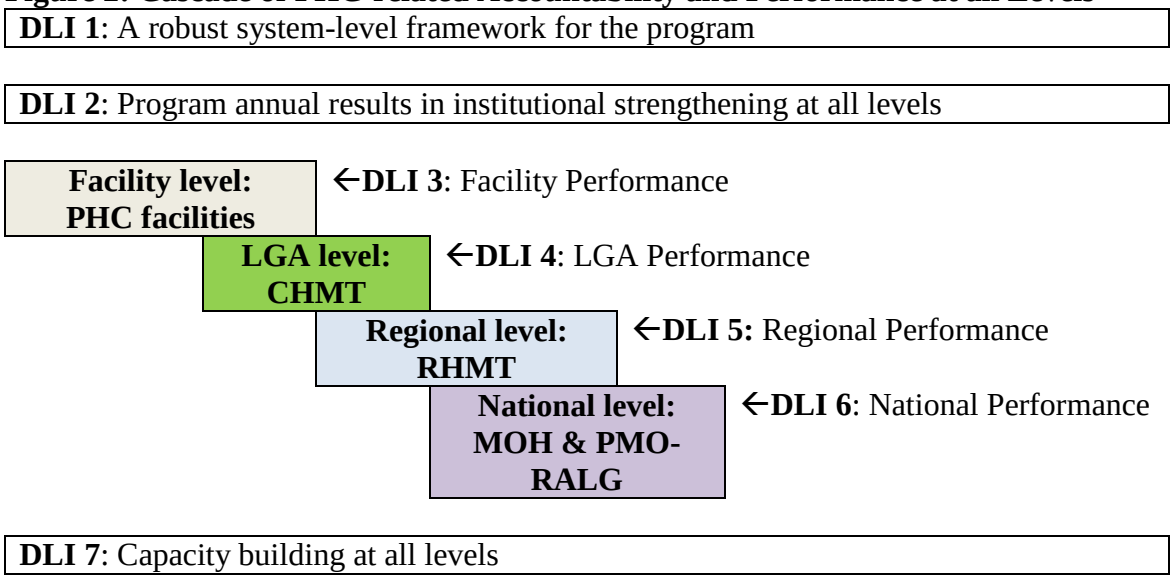
30. **A set of disbursement-linked indicators (DLIs) for the program will form the basis of disbursement.** The use of such DLIs is expected to sharpen the program by sending a signal to key stakeholders to focus on critical results. The following principles were applied when formulating these DLIs:

i. maximizing the use of existing indicators in the government's program, especially those in HSSP IV and BRN;
ii. corresponding to the key priority areas of PHC in HSSP IV; especially the major bottlenecks along the results chain and providing incentives for removing them;
iii. stimulating performance at all levels of the system: national, regional, LGA and PHC facility;
iv. prioritizing the use of the government's routine information system (DHIS2) and existing reporting mechanisms (i.e., RMNCAH scorecard) for sustainability
v. balancing ambition ("stretch") and feasibility ("realism");
vi. taking into account a reasonably even distribution of disbursements; and,
vii. where applicable, undisbursed amount of IDA financing for a DLI in a given year will be rolled-over for use in subsequent years (with a cap).

31. There are a total of 7 DLIs, of which five are composite with sub-criteria. They are a combination of actions, intermediate outputs, and output. DLI 1 ensures that a robust framework for the program has been established. The rest, DLIs 2-7, form a chain of PHC-related accountability and performance at all levels in the system (Figure 2).

[12] The "star rating" accreditation scale is from 1 to 5 stars, with 5 being the best quality and 3 being the minimally accepted.

Figure 2: Cascade of PHC-related Accountability and Performance at all Levels



32. Table 4 summarizes the 7 DLIs. It should be noted that as DLIs 4, 5, 6 and 7 follow the N+1 principle (pay for the performance of the previous year); there will be no disbursement against them in Year 1.

33. **Other development partners contributing to the health basket fund (the pooled funding mechanism to support the operating cost of PHC in the country) will also adopt DLIs 2, 4, 5 and 6 for their own disbursements**. DLI 3 will also form the basis for disbursement under the single donor trust fund from USAID.

Table 4: Summary of Disbursement Linked Indicators

Priority Area	***DLIs***	***Indicative Attainment Schedule***					***Disbursement frequency & approach***	***US$ M****
		Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**		
Program's foundational activities	DLI1: Recipient has completed all foundational activities	X	X				US$2 million each for the first five activities upon achievement and US$10 million for the sixth activity	20
Institutional performance at all levels	DLI 2. Recipient has achieved all of the Program annual results in institutional strengthening at all levels (national, regional, LGA and facilities)	X	X	X	X	X	Annual All-or -nothing	75
Performance at facility level	DLI 3. PHC facilities have improved maternal, neonatal and child health service delivery and quality as per verified results and received payments on that basis each quarter	X	X	X	X	X	Quarterly Sliding scale	100
Performance at LGA level	DLI 4. LGAs have improved annual maternal, neonatal and child health service delivery and quality as measured by the LGA Balance Score Card		X	X	X	X	Annual Sliding scale	82
Performance at regional level	DLI 5 Regions have improved annual performance in supporting PHC services as measured by regional Balance Score Card		X	X	X	X	Annual Sliding scale	2.4

Performance at national level	DLI 6. MOHSW and PMO-RALG have improved annual PHC service performance as measured by the national Balance Score Card		X	X	X	X	Annual Sliding scale	5.6
Capacity building	DLI 7. Completion of annual capacity building activities at all levels		X	X	X	X	Annual Sliding scale	15

**This includes the USAID single donor TF as well as financing from GFF and ANIS MDTF*

***DLI 1*: Recipient has completed all foundational activities**

34. *DLI Description:* DLI 1 is the completion of foundational activities to ensure a robust system-level framework for the program. It has six results related to the preparation for capacity building, data quality improvement, fiscal decentralization, facility accreditation and availability of BEmONC and CEmONC services in the five BRN MNCH regions (see Annex 3 for details). Each result has an allocation and disbursement is made on sliding scale basis.

35. *Theory of Change:* These are basic requirements to ensure smooth operation of the program.

DLI 2: Recipient has achieved all of the program annual results in institutional strengthening at all levels (national, regional, LGA and facilities)

36. *DLI Description*: DLI 2 is the completion of 6 program results in institutional strengthening which GOT needs to meet every year. Each result corresponds to a specific sector bottleneck which hinders the provision of critical inputs for quality of care; namely planning, budgeting, financial management, human resources for health, and information on quality of care (see Annex 3 for details); each result has an annual target. Each year, disbursement for this DLI will be made on an all-or-nothing basis. Undisbursed amount of IDA financing for this DLI in a given year will be rolled-over for use in subsequent years, with a cap.

37. *Theory of Change*: To produce quality care, PHC facilities need critical inputs such as resources and skilled staff. Although such inputs are not guarantees for quality of care per se, they present the bare minimum requirements for quality. Various institutional challenges in public finance management and human resources for health prevent such inputs from reaching frontline providers. Also, there is no regular, systematic assessment of quality of care at the provider level to hold them accountable for results. The fulfilment of annual minimum conditions represents Tanzania's progress in addressing such bottlenecks at all levels.

DLI 3: PHC facilities have improved maternal, neonatal and child health service delivery and quality as per verified results and received payments on that basis each quarter

38. *DLI Description*: DLI 3 represents quarterly performance of MNCH services at the PHC facility level. As per the program description section, the GOT plans to roll out the RBF scheme for PHC facilities in 7 regions. Under this scheme, each PHC facility will receive additional

quarterly payments according to its level of performance in: (i) provision of essential maternal, neonatal and child health services; and (ii) quality of care as elaborated in the program operational manual. Provision of such services includes, *inter alia*, timely ante-natal and post-natal care, institutional deliveries, family planning as well as prevention of mother-to-child transmission of HIV as reported in the existing health management information system (HMIS). Each service has a different unit cost. Quality of care will be assessed quarterly with regard to (i) conditions to provide care (in other words, availability of essential supplies and equipment, water, health care waste management, infection control practices, facility-level accountability mechanisms (i.e.) Health Facility Governing Committee (HFGC) meetings held), attention for vulnerable populations including adolescents; (ii) contents of patient care as reflected in medical records; and, (iii) patient satisfaction. The result of quality of care assessment is expressed in percentage.

39. Internal verification of results will be carried out quarterly (by a team of regional officials and civil society organizations, using standardized protocols) for every PHC facility in the scheme. On the basis of results verification, the GOT will pay incentives to the facilities in the scheme. RBF payments for dispensaries and health centers will be a function of quantity and quality of care. For district hospitals, RBF payments will be exclusively based on quality of care. As facilities' performance improves, RBF performance indicators will be adjusted over time to expand the performance frontiers and keep providers on their toes. In addition, the scheme also provides incentives for PHC facilities to fulfil their roles in civil registration especially birth and death registration. Counter-verification by Controller and Auditor General (CAG) or Internal Auditor General (IAG)[13] will be carried out for a random subset of facilities to prevent over-reporting of results. The design of the RBF scheme is in line with best practices of RBF schemes supported by the World Bank in more than 30 countries (see Annex 1 and Annex 4 for more details on the RBF design and its technical soundness).

40. Under DLI 3, the operation will reimburse the GoT quarterly for the (i) actual incentive payments to PHC facilities in the RBF scheme and (ii) the operating and verification costs of the scheme (as a percentage of the total incentive payment). Quarterly disbursement for this DLI will be on a sliding scale basis.

41. *Theory of Change*: The GOT's performance-based incentive scheme for PHC facilities known as the results based financing (RBF) in essence represents an incentivized continuous quality improvement program. In Tanzania, this is the first time that on a large scale, each facility is being held accountable for its own performance in service delivery. The scheme is robust and in line with best practices emerging from thirty-eight pay-for-performance programs at the provider level supported by the World Bank globally (see Box 1). In such a scheme, internal verification of results is crucial. DLI 3 therefore reflects a major recurrent milestone in the implementation of the scheme to stimulate the performance of PHC facilities. It means implementers have carried out the following:

[13] Final arrangements for counter-verifications under the RBF scheme will be specified in the program operations manual (POM).

- PHC facilities have completed the implementation of their quarterly RBF business plans.
- Internal verification has been carried out to verify the achievement of each PHC facility against an extensive list of facility level performance indicators.
- Facilities have received their incentive payments within 28 working days after the verification of results.

Box 1: Results-based Financing -- A Smarter Approach to Delivering More and Better RMNCAH Services

RBF at the facility level is defined as a cash payment or nonmonetary transfer made to health facilities after predefined results have been attained and verified. This approach helps providers to better achieve results through the following mechanisms:

- Linking payment to results based on context-specific health priorities;
- Enforcing a contractual relationship between purchaser/financier of health services and service providers in which the respective responsibilities of all stakeholders are clearly defined;
- Introducing more autonomy for facilities to use RBF funds to attain the pre-agreed results;
- Empowering frontline providers and health facility manager;
- Using verification and counter-verification methods to ensure actual results have been achieved;
- Enabling the use of real time data by program managers and facilities to better plan, monitor and develop solutions of their own in order to improve performance; and
- Facilitating community involvement which acts as a social accountability mechanism.

Since 2008, the World Bank has been supporting 38 RBF schemes at the provider level in 32 countries around the globe. A review of the first phase of the World Bank's support for RBF (though the Health Results Innovation Trust Fund) has provided solid evidence that this approach can improve health outcomes by increasing access to better quality and more equitable services, and promoting greater efficiency in even the poorest countries. Key lessons from in-depth reviews of the RBF programs in Argentina, the Democratic Republic of Congo, Nigeria, Zambia, and Zimbabwe are particularly insightful. With the support of the World Bank, the GOT has incorporated such lessons in the design of the RBF scheme in Tanzania on the basis of the Pwani pilot.

Source: RBF: A Smarter Approach to Delivering More and Better Reproductive, Maternal, Newborn, and Child Health Services, The World Bank, 2014

DLI 4: LGAs have improved annual maternal, neonatal and child health service delivery and quality as measured by the LGA Balance Score Card

42. *DLI Description*: DLI 4 represents annual performance in MNCH service delivery at the LGA level. Such performance is assessed annually for each LGA, using a LGA Balance Score Card (BSC). The BSC has 12 criteria with different weights (according to level of importance and difficulty of each criterion), the majority being the GOT's own indicators (either from BRN in Health or RMNCAH scorecard which quarterly monitors LGA level performance on maternal and

child health indicators and reports to the President's office) (See Annex 3 for details). The 12 criteria, broadly speaking, can be categorized in two groups:

- Six criteria related to "Maternal, Neonatal and Child Health Service Delivery Outputs"
- Six criteria related to "Improving Conditions for Quality of Care"

Annual disbursement for this DLI (i) only takes place when the country as a whole achieves a minimum threshold of the LGA BSC and (ii) is on a sliding scale basis.

43. *Theory of Change:* In Tanzania, this is the first time that each LGA is being systematically held accountable for its performance in service delivery. The content and structure of balance score card correspond to key challenges or bottlenecks in the production of quality of care identified by the GOT under the BRN in Health exercise.

44. As discussed in the sectoral context section, low quality of care results in lower utilization of certain MNCH services. For example, a woman might deliver her first child in a health facility, but due to her bad experience and perceived poor quality of care, does not return for subsequent child births. In that context, some of the "service delivery outputs" such as increase in institutional deliveries can be seen as a proxy (albeit imperfect) for improved quality of maternal care. Others such as ANC attendees receiving iron and folic acid supplementation or two doses of IPT2, children receiving vitamin A supplementation are about the clinical interventions which clients actually receive as part of ANC and child health visits, and therefore serve as quality of care indicators which can be incentivized. All of the service delivery outputs are also among the most cost-effective interventions in public health.

45. The second group of criteria correspond to improvements in the conditions for the provision of quality care and facilitate the achievement of the first group. In quality of care literature, such improvements are also known as "improved structural quality of care". In HSSP IV, under the GOT's "Star Rating" accreditation initiative, once the initial assessment has been carried out, each facility will have a quality improvement plan and efforts will be made to help such a facility achieve a higher Star Rating subsequently. A special emphasis will be put on this criterion in the LGA BSC to motivate the accreditation process. Other criteria correspond to LGA improvement in HSSP IV and BRN priority areas such as HRH, availability of essential drugs, and social accountability. In addition, as the DHIS2 is the backbone of the health information system in the country and serves as source of information for many DLIs, there is a criterion to incentivize the completeness of data entry at the LGA level.

DLI 5: Regions have improved annual performance in supporting PHC services as measured by Regional Balance Score Cards

46. *DLI Description*: DLI 5 represents annual performance in supporting PHC services at a regional level. Such performance is assessed annually for each region, using a Regional Balance Score Card (BSC). The BSC has two criteria related to supportive supervision and data quality audit by RHMT for LGA. Each criteria has a different weight (according to level of importance and difficulty). Disbursement for this DLI is made annually and on a sliding scale basis.

47. *Theory of Change*: This is the first time in Tanzania that each RHMT is systematically held accountable for its performance. The key roles of RHMT is to provide implementation support to LGAs, especially in two key areas: (i) supportive technical and management supervision and (ii) data quality audits. By incentivizing RHMTs along the lines of their key functions, the GOT will stimulate their performance, which in turn will contribute to improvement in the production of quality of care at the levels of LGA and health facilities.

DLI 6: MOHSW and PMO-RALG have improved annual PHC service performance as measured by the National Balance Score Card

48. *DLI Description*: DLI 6 represents annual performance by MOHSW and PMO-RALG in support of PHC services at the local level. Their performance will be assessed annually using a National Balance Score Card with 4 criteria related to: (i) performance of all LGAs; (ii) performance of all regions; (iii) their support for lower levels and; (iv) public financial management. In this BSC, national implementers will thus be held accountable for the performance in PHC service delivery at the lower levels. Each criteria is given a different weight according to its level of importance and difficulty. Disbursement for this DLI will be made annually and on a sliding scale basis.

49. *Theory of Change*: The key roles of MOHSW and PMO-RALG are to provide stewardship, regulations and implementation support to lower-level implementers (RHMT, CHMT, facilities). In DLI 6, by using the LGA and regional scores (derived from DLI 4 and 5) in the balance score card for national performance, the two ministries are directly held accountable for the performance of RHMT and LGAs nation-wide. This is expected to motivate the ministries to better carry out their functions to support the achievement of PHC service delivery at the frontline.

DLI 7: Completion of annual capacity building activities at all levels

50. *DLI Description*: Under the foundation activities in DLI 1, the GOT will prepare a 5-year capacity building plan related to PHC at all levels. The plan will be reviewed and agreed each year between the GOT and IDA. This DLI represents the extent of completion of such activities in the agreed plan in the previous fiscal year. Disbursement for this DLI will be made annually and on a sliding scale basis.

51. *Theory of Change*: Various capacity gaps have been identified in Section D. Addressing such gaps is essential to ensure the success of the program.

D. Key Capacity Building and Systems Strengthening Activities

52. **Capacity constraints remain a challenge in Tanzania's health sector.** Under the program, such constraints exist at all levels in various areas, *inter alia*: (i) the capacity to implement quality of care interventions, including RBF, performance management, accreditation, etc.; (ii) supply chain management; (iii) public finance management; (iv) social accountability; and (iv) monitoring and evaluation (M&E).

53. **To address this challenge, the GOT is preparing a comprehensive capacity building program at all levels as part of PHC strengthening under HSSP IV.** The GOT's plan under development has the following principles:

- Targeting the "weakest links" at various levels while prioritizing implementers at the front line (health workers, council and regional health management teams)
- Balancing between technical (including social and environmental) vs. management (including fiduciary) capacity building
- Promoting on-the-job learning
- Encouraging peer-to-peer learning, especially learning from outstanding performers ("positive deviants")
- Combining training with feedbacks and post-training follow-ups
- Sensitizing implementers about new initiatives such as BRN in Health and their respective roles and responsibilities
- Including "non-traditional" yet important stakeholders such as Health Facility Governance Committees and Council Health Service Board in capacity building

54. **The GOT's comprehensive five-year capacity building plan will be jointly financed by the GOT and various DPs through parallel financing.** For instance, USAID has in addition to the single donor trust fund, a US$70 million project over the next five years aimed at improving planning, financial management and governance at the LGA level. GOT resources for capacity building will be allocated through the annual planning process under the medium term expenditure framework (MTEF) and CCHP. Since capacity needs might change over time, the plan can be subject to revision as needed. To facilitate the finalization and implementation of such capacity building plan, as discussed above, the PforR will have (i) one foundational activity in DLI 1 related to the finalization and adoption of the plan in Year 1 and (ii) one DLI (DLI 7) related to the annual implementation of the plan.

III. PROGRAM IMPLEMENTATION

A. Institutional and Implementation Arrangements

55. **The Program's implementation will be based on the current institutional arrangements for the delivery of PHC services**. In Tanzania, the Ministry of Health and Social Welfare (MOHSW) and the Prime Minister's Office – Regional Administration and Local Government (PMORALG) will be jointly responsible for ensuring achievement of HSSP IV results, including the specific outcomes of the BRN in Health and RBF implemented at the local level.

56. **The MOHSW, as the steward of the health system, is responsible for health policies, strategies, regulations, coordination and oversight for the sector and the program.** It leads the development of health sector strategic plans (HSSP) and the medium term expenditure framework (or MTEF, which forms the basis for health sector budget allocations) on a rolling basis. MOHSW also exerts stewardship functions over various health agencies such as the Medical Stores Department (MSD), the Tanzania Food and Drugs Authority (TFDA) and the National Health Insurance Fund (NHIF).

57. **PMORALG, through the LGAs, is responsible for coordinating, providing administrative support and allocating resources for the delivery of PHC services.** In Tanzania's decentralized setting, funds for development and recurrent expenses are transferred from the Treasury to the LGAs, and from the LGAs to the health facilities. LGAs ensure proper accounting at the facility level. In this context, the roles of PMORALG are to: (i) support LGAs in the provision of quality health services; (ii) manage the critical interfaces with MOF, MOHSW, DPs and LGAs; (iii) monitor the support by Regional Administrative Secretariats (RAS) to LGAs; (iv) provide advice, information and capacity building to RAS and LGAs in policies, approaches, systems and planning methodologies. The Council Health Management Team (CHMT) plays an important role in planning and decision-making at the LGA level. It manages district health services and reports to the District Council. At the regional level, the Regional Health Management Team (RHMT) is to: (i) provide technical support to LGAs for the implementation of the Program; (ii) identify capacity building needs; and (iii) monitor, supervise, and evaluate health services, including data quality audits.

58. **Health facilities (public, faith-based and private) at the LGA level are responsible for delivering PHC services, in line with Tanzania's decentralized health service delivery system**. As such, they will implement the program at the grassroot level.

59. **The BRN in health implementation will be mainstreamed through MOHSW, PMORALG and LGA structures.** The President's Delivery Bureau (PDB) oversees BRN in Health through collaboration with Prime Minsters Office, MOHSW and PMORALG. In the program delivery system, PDB is responsible for: (i) problem solving and solution generation through providing feedback, advice and recommendations; (ii) facilitating the development of performance contracts of Ministers for MOHSW and PMORALG for purposes of accountability for results; and (iii) reporting on progress/actions on BRN Health implementation plans to the Transformation Delivery Council. Additionally, the MOHSW has established a Ministerial Delivery Unit (MDU) for coordinating and monitoring the implementation of activities in the BRN in Health initiative. The MDU will ensure effective coordination and linkages between work streams supported by various Departments, sections, units and agencies.

60. **The GOT has developed a RBF scheme which will be used to pay facilities based on their performance which will be incentivized under DLI 3.** This scheme provides quarterly incentive payment to PHC facilities according to their levels of achievement of a set of performance indicators which are independently verified. Phase 1 of the roll-out of this scheme aims to cover at least 7 regions by 2020. The scheme's implementation and institutional arrangements will be mainstreamed into current government structures and are as follows:

- As parts of its regulatory mandate, MOHSW will be responsible for developing RBF-related policies, guidelines and tools as well as providing clinical and technical oversight and supervision for RBF implementation. In the Department of Policy and Planning of MOHSW, a national RBF team has been established to oversee the implementation and roll out of the scheme on a day-to-day basis.

- The National Health Insurance Fund (NHIF) as the largest public health insurer in Tanzania will carry out the role of purchaser. The NHIF will enter into agreements with providers of health and/or management services, of a specified quality.

- In RBF regions, eligible participants include public facilities and select private facilities in areas where service gaps exist or with whom service agreements are already in place for select services. They also need to pass a minimum readiness threshold through a facility assessment. Council and regional health management teams as well as Medical Stores Department (MSD) and their strategic business units (SBUs) will also be paid performance-based incentives.

- To ensure that payment will be based on accurate results, verification will be carried out prior to payment by a Regional Administrative Secretariat (RAS) identified team. This verification team will consist of representatives of RHMT, the regional NHIF office as well as civil society organizations to ensure transparency and prevent possible conflicts of interest. Once a year the Controller Auditor General Office will counter-verify the verified results on a sample basis and penalize the verification team if deemed necessary.

- Performance-based payment will be made on a quarterly basis by the Ministry of Finance (the fund holder) directly into each participating entity's bank account.

- The Prime Minister's Office - Regional Authority for Local Government (PMO-RALG) will play a vital role as facilitator to ensure local government authorities function effectively and to provide assistance, guidance and supervision to health facilities, councils and regional secretariats.

B. Results Monitoring and Evaluation

61. **To the fullest extent possible, this operation adopts GOT's own indicators as PDO, intermediate and disbursement linked indicators and uses GOT's routine information systems to monitor them.** Out of 19 indicators in the results matrix**,** 12 are GOT's own indicators as per HSSP IV and BRN in Health. All of the program indicators will be monitored by the GOT's routine information system. This approach aims to (i) align the operation's M&E with that of the GOT, (ii) increase GOT's ownership in the results matrix, (iii) strengthen GOT's M&E systems and ensure their sustainability.

62. **Five key information systems will generate data for the program indicators.** They are: (i) District Health Information System (DHIS-2) which includes information on service delivery by PHC facility; (ii) Logistics Management Information System (LMIS) which includes information on supply chains management for health; (iii) Human Resource for Health Information System (HRHIS) which includes information on staffing; (iv) Planning and Reporting (PLANREP) which includes information on council health plans and their implementation; and (v) Integrated Financial Management Information System (IFMIS) which includes financial management by LGA. The first three information systems are maintained by MOHSW, while (iv) and (v) are maintained by PMO-RALG and MOF respectively.

63. **The GOT has developed data interfaces for dissemination and use of data at the district level which are publicly accessible and will form the basis for regular M&E of this program**. First, the MOHSW is rolling out nationwide *District Health Profiles* (DHP) which tracks the progress in health status, health systems and service delivery at the district level systems

and health services delivery. Second, a *Master Facility List* (MFL) listing all health facilities public and private) in the entire country is near completion. Integration between DHIS2 and MFL was initially started in early 2014 to address operational standards and uniformity of health facilities between DHIS2 and MFL. With standard set of health facilities between systems, it will allow sharing DHIS2 information with any other health information system compliant with DHIS2 and MFL facility registry. Third, the *RMNCAH Scorecard* is a tool developed to track progress in delivery of RMNCAH services at the LGA level on a quarterly basis and foster an environment of accountability at all levels at the request of the President of Tanzania. This card uses HMIS National data warehouse data, generates a progress report every quarter and tracks improvements in key interventions for maternal, newborn and child survival and is shared with the highest levels of Government.

64. **The quality of GOT's information systems will be further strengthened during the program period.** DHIS-2, as the backbone of the GOT's health information system, generates data for many results and indicators in the results matrix. To help improve the quality of DHIS-2, the GOT plans to use RHMTs to conduct data quality audits (DQA) for all LGAs at least twice a year. Such activities will be parts of the Program. As per the above section on DLIs, incentives will be provided for (i) LGAs to improve the completeness and timeliness of their DHIS-2 data and (ii) RHMTs to conduct DQA for LGA, using standardized protocols. In addition, during the next five years, other health-related routine information systems will be further strengthened in MOHSW, PMORALG and health facilities as parts of the government's program with the support of various DPs. Health is one of the priority sectors under the Open Government Partnership for Tanzania, in which GOT is committed to improving quality of data on public services and making them public for transparency. This will facilitate the monitoring of various indicators in the results framework.

65. **Evaluations will be carried out for selected activities of the program.** For selected innovative interventions such as RBF roll-out, the government, with the support of the World Bank and the government of Norway, plans to carry out a rigorous impact evaluation of the RBF activity, using an experimental design. The aim is to generate evidence on the cost-effectiveness of RBF activities to (i) fine-tune RBF design and (ii) inform policy making**.**

66. **The program M&E is an integral part of the health sector's M&E under the sector Wide Approach (SWAp) and GFF monitoring will build on this process.** The SWAp arrangements in Tanzania have well-established M&E arrangements, including the Joint Annual Health Sector Review (JAHSR) which discusses the progress of HSSP implementation, the MTEF, and the CCHP. The review of the program will be part of the JAHSR as well as other SWAp M&E mechanisms. The GFF country harmonization platform envisages that all partners will work around a shared investment case and engage in joint monitoring of the performance. The GFF will build on these existing platforms.

67. **The program M&E will also benefit from M&E arrangements for BRN in Health**. BRN in Health has its own arrangements to monitor the key performance indicators for its four work streams. Progress under BRN in Health will be monitored weekly and monthly (where applicable) by the MDU team within MOHSW, and then collated by the newly established President's Delivery Bureau into a public Annual Report. As many of the program indicators are

derived from the BRN in Health, Program M&E will benefit from such BRN in Health M&E arrangements.

C. Disbursement Arrangements and Verification Protocols

68. **Disbursements will be made upon the presentation and verification of evidence of attainment of the Program's disbursement linked indicators (DLIs).** Disbursement arrangements include the following key features:

- DLI 1 will be disbursed as each foundational activity is achieved.
- DLI 2 will be disbursed on an all-or-nothing basis.
- All the remaining DLIs will be disbursed on a pro-rated basis to recognize partial achievements.
- Disbursement will be made (i) only once for DLI 1 (foundational activities), (ii) annually for DLI 2; (iii) quarterly for DLI 3; (iv) annually but not in Year 1 for DLIs 4, 5, 6 and 7.
- For selected DLIs, MOF will be able to request a disbursement should the DLI be achieved *earlier* or *later* than the agreed dates in the same fiscal year.
- Advances of up to 25 percent of the total disbursement value for selected DLIs will be available at effectiveness to support the GOT in designing and/or implementing activities which could benefit from earlier funding to increase the likelihood of timely achievement of results.

69. **The government has appointed the Internal Auditor General's (IAG) office as the independent verification agency for the program with defined terms of reference (TOR) satisfactory to the World Bank**. The verification agency will carry out annual verification for all DLIs, using well-defined protocols.

70. Verification protocols and schedule for the program's DLIs can be summarized as follows:

- MOHSW will submit self-reported data on DLI achievement to the World Bank and the verification agency. On that basis, the verification agency will verify results.
- For process DLIs, verification will involve a review of administrative data (i.e., DHIS2, Integrated Financial Management Information System), documents, and records.
- For LGA service delivery outputs under DLI 4, verification will be done by checking medical records and registries *vis-a-vis* DHIS-2 data in a random sample of LGAs and facilities.
- The verification agency will submit a final verification report to the World Bank, upon review of evidence against protocols.
- The World Bank will reserve the right for further due diligence on the robustness of data (including random spot check) as needed.
- As HBF development partners will also use DLIs 2, 4, 5 and 6 for their disbursement into the government's HBF holding account, they will also coordinate with the World Bank to ensure partners' due diligence for the soundness of data for these DLIs.

- To ensure timely disbursement, there will be a clear annual schedule with specific milestones for (i) GOT's submission of self-reported data (ii) verification of results by third-party entity and (iii) due diligence by World Bank and HBF partners.

71. **For facility level results under DLI 3, detailed mechanisms for reporting, verification, counter-verification and payments have been outlined in the government's RBF operational manual.** To ensure that payment will be based on accurate results, verification will be carried out prior to payment by a regional Administrative Secretariat (RAS) identified team. This verification team will consist of RHMT members and include members of the regional NHIF office as well as civil society organizations to ensure transparency and prevent possible conflicts of interest. Once a year the CAG's Office or IAG will counter-verify the verified results on a sample basis and penalize the verification team if deemed necessary. The payment will be made on a quarterly basis by the Ministry of Finance, as the so-called fund holder, directly in to the relevant providers' bank account.

72. **Specific details related to flow of funds, in terms of paying for results, will be detailed in the program operational manual**. The program operational manual will contain detailed information on procedures to be followed at each stage of the transaction cycle, including commitments, transaction verification and approval, payments and reporting.

IV. ASSESSMENT SUMMARY

A. Technical

Program's strategic relevance and technical soundness of the approach

73. **The GOT's HSSP IV is comprehensive and technically sound.** It encompasses service delivery by (i) different levels of care, (ii) different vertical disease control programs, and (iii) all the relevant support systems. HSSP IV is accompanied by an action plan and a monitoring framework.

74. **HSSP IV has a strong focus on PHC, which is the cornerstone of the Tanzania national health policy and forms the basis of the pyramidal structure of healthcare services in Tanzania.** Within PHC, maternal and child health and nutrition are prioritized. Without effectively addressing such challenges, Tanzania will not be able to significantly improve health outcomes and benefit from the economic and welfare gains of better health. In this context, the Program represents a significant portion of the government's broader program and aims to address some of the most critical cross-cutting bottlenecks in PHC which hinder results in maternal and child health. BRN in Health is a major initiative for PHC under HSSP IV for this purpose.

75. **The President's BRN initiative focuses on improving results in key priority sectors, taking into account the global evidence as well as the Tanzania context**. Under the overall BRN umbrella, the BRN in Health program was developed through an intensive six-week "Health Lab" process of consultations and syndications. It involved 138 representatives from 65 agencies representing key stakeholders in the sector including academics, government officials, DPs, CSOs, private sector representatives and others. A total of 32,000 person hours was devoted to the development of BRN in Health.

76. **The BRN in Health has a strategic design which is guided by the key principles of effectiveness, efficiency, equity and accountability.** It supports evidence-based, cost-effective technical interventions. Accreditation has been shown to improve quality of care in both advanced and low and middle-income countries –LMICS– (although the number of evaluations for LMIC is fewer). The same applies to quality improvement plans for health facilities. Fiscal decentralization contributes to provide greater managerial autonomy, which in turns facilitates improved service delivery. Social accountability is universally accepted as a mechanism to hold providers accountable for results as per the World Development Report 2004 conceptual framework. HRH represents a critical input for quality of care and, in fact, part of a dimension of quality which is known as "structural quality". For maternal and neonatal care, the two service packages, BEmONC and CEmONC, are WHO standards which are essential to quality service for mothers and newborns.

77. **As part of the BRN Performance Management work stream, the GOT plans to scale up RBF for 7 regions.** Facility-based incentives (or RBF) were already a priority in the ongoing Health Sector Strategic Plan 2012-15 (HSSP III). The GOT plans to scale it up in HSSP IV. There is an emerging global body of evidence on the effectiveness of RBF in improving health workers' performance in low and middle-income countries, including performance related to quality of care**.** The GOT's RBF design benefits from a wealth of practical experiences generated by RBF schemes supported by the World Bank in 32 different countries (many of them are in Sub Saharan Africa). The design also takes into account Tanzania-specific issues. The list of payment indicators in the RBF scheme balances pay-for-quantity vs. pay-for-quality to incentivize the delivery of a set of cost-effective interventions at the PHC level. Special attention was paid to ensure there is no overlap between RBF and other activities under the BRN Performance Management work stream.

78. **There are various mechanisms put in place by the GoT to ensure the program's success by holding various actors accountable for results at all levels along the hierarchy. These include:**

- At the front line, service providers will be held accountable for their own results through RBF and other non-monetary accountability schemes under the BRN Performance work stream. Also, various social accountability mechanisms will be used at the facility level (health facility committees, use of CSOs for verification of results for RBF).
- At the council level, each CHMT will be systematically held accountable for its own performance as well as aggregate performance of all PHC providers in the council jurisdiction.
- At the regional level, RHMT will be held accountable for its performance in supportive supervision to LGAs and data quality audit.
- At the national level, MOHSW and PMO-RALG will be held accountable for the performance of all PHC providers in the country.
- In addition, there will be governance and delivery structures at different levels for BRN (PDB, MDU, NKRA Steering Committee).
- Last but not least, a very high level of country ownership in HSSP IV and BRN in Health is a major enabling factor for future program results.

Program expenditure framework

79. **The medium term financial prospects of Tanzania appear to be sound with stable GDP growth and steady inflation.** Primary health care is a priority under the BRN starting in 2015/16. While the health sector share in the budget has been declining in recent years, government contribution has been increasing and the inclusion of the health sector in the BRN is expected to further support this trend. Public spending in the sector is allocated efficiently with significant resources aligned to primary and preventive care services. The BRN in Health supported under the program, furthers this objective through its focus on increasing resources for cost-effective primary care interventions especially in areas with high burden of maternal, neonatal and child mortality. The program also addresses inequities in health personnel distribution in rural and poorer areas and inefficiencies in service delivery through improved distribution of medicines, reduced wastage, enhanced citizen engagement in service delivery and incentivized health worker performance.

80. **Government intervention in the health sector at the primary care level supported by the program is strongly justified in Tanzania on the grounds of improving equity, as well as positive externalities and public goods.** The poor are highly dependent on the public sector for services, especially in the rural areas where choices are limited. However, quality of care in PHC facilities is low. Public subsidy is thus called for to improve quality of PHC care where the poor access services. Improved quality of care also means improved technical efficiency. It should therefore help reduce overall costs in the medium to long-term. The BRN in Health and the program with an emphasis on increased resources to primary care, encourages domestic funding to focus on areas where there is a clear role for government. Further, under the health facility based incentives, facilities are incentivized for providing services to the extreme poor as identified by the conditional cash transfer (CCT under PSSN) program thus directly targeting those most in need. Additionally, as geographic inequality in health block grant distribution amongst LGAs remains substantial and continues to widen, the program emphasizes the allocation of resources in a more equitable manner including the promoting an equity formula for distribution of resources to LGAs.

81. **The program supports strengthening fiscal decentralization to the level of the health facilities to foster innovation and cost-effective local solutions.** Decentralization of service delivery in Tanzania is still incomplete with local governments still reliant on central levels for key inputs (medicines, part of operating cost funding etc.). The introduction of bank accounts at the facility level with clear financial management guidelines, supported and incentivized by the program, brings resources closer to where services are delivered and helps foster local solutions to shortages in health personnel and medicines.

82. **Key beneficiaries of the program are women of reproductive age (including adolescents) and children under the ages of five; key program indicators will be monitored by gender.** The BRN in Health supported by the program prioritizes regions with highest burden of maternal, neonatal, and child mortality. In addition, it aims to target and expand coverage of selected evidence-based interventions in RMNCAH that will have the greatest impact on lives saved through strong district level support in decision-making and implementation.

83. **Widespread shortages of qualified health workers especially in rural and poor districts result in the delivery low quality of primary care services to those most in need**. Redistribution of skilled personnel, especially at the dispensary level with a focus on regions with critical shortages as planned under BRN HRH work stream and supported by the program, is expected to further reduce inequities at the LGA level. The program also supports and incentivizes the National Community Based Health Program Strategic Plan 2015-2020 which aims to develop a cadre of community health workers to bring services closer to the population and promotes efficiency and health worker performance management through incentives, contracts and recognition; it also provides opportunities for hiring of skilled HRH through PPP/Private sector engagement.

Results Measurement

84. **A set of specific, measurable and relevant indicators was agreed with the GOT to monitor the program.** As part of the M&E harmonization agenda under SWAP, the vast majority of program indicators were extracted from the government's M&E framework (e.g. HSSP IV and BRN in Health indicators). Further, as previously stated, program results will be monitored through the routine health management information system (DHIS2) and other administrative data systems of MOHSW and PMORALG described in section B "Results Monitoring and Evaluation". These are deliberate choices to (i) align program's monitoring methodology with that of the government and increase ownership of the results; (ii) reduce the country's reliance on surveys to monitor progress; (iii) maximize the use of routine information platforms such as the district health profile (DHP) and RMNCAH scorecard; (iv) help further strengthen the country's information systems; and (v) reduce fragmentation in M&E.

85. **The cornerstone of the PHC information system is the DHIS2 which is used for data aggregation, analysis and reporting from LGA to regional and national levels.** Under HSSP III, Tanzania completed its country wide rollout of DHIS2 in 2013 after deploying a revised HMIS tool nation-wide. Dispensaries and health centers use paper based information systems and then send their data to the district for the CHMT to enter online into the National Data Warehouse. Some district hospitals have started using computer based systems for data entry, analysis and reporting. In addition to DHIS2, the MOHSW has rolled out other improved information systems for human resource management (HRHIS), training institutions (TIIS) and CCHP Planning and reporting (PlanRep) while PMORALG has rolled out a financial reporting system (EPICOR). Though there are many challenges and issues to be addressed, these systems all aim to improve the M&E of PHC and facilitate availability of integrated technical and financial reports from LGA.

86. **Deficiencies in the existing M&E systems are well documented and the program is supporting efforts to address them.** First, PHC facilities still focus more on data collection and reporting than on utilization for decision making. Second, incompleteness of data entry in certain LGAs is a concern. Third, LGAs have limited capacity to check data quality, conduct analysis and provide feedback to lower levels. Fourth, there is a need to coordinate various systems at the local levels such as PlanRep, EPICOR, and HRHIS to promote the integration between program monitoring and performance appraisal. Finally, the civil registration and vital statistics system (CRVS) is poorly functioning and few births and deaths are registered. In order to address these inefficiencies, several steps are being undertaken under the program, as follows:

- The MOHSW has introduced a district health profile template for use by LGAs. This is produced quarterly and annually to stimulate data use at all LGA levels.
- The MOHSW produces a RMNCAH scorecard on a quarterly basis using DHIS2 data to track progress on key maternal and child health service delivery indicators which is shared with the highest levels of Government.
- MOHSW is developing a data quality audit mechanism to improve the completeness and quality of DHIS2 data. Also, through the RBF program, the MOHSW has introduced quarterly data verification at facility level by CHMT.
- A full time district M&E officer will now replace the part time HMIS focal person at the LGA.
- The process of harmonization of PlanRep and EPICOR is ongoing. The National Sample Vital Registration and Verbal Autopsy is being rolled out by Ifakara Health Institute, the National Institute for Medical Research, and MOHSW.
- A data repository at national level with district data is being developed to include data from DHIS2, HRHIS and TIIS.

Program economic evaluation

87. **The Program supports improvements in quality of primary care services with the focus on maternal, neonatal and child health.** There is considerable amount of literature that points to the efficacy of primary care services. Primary care services are associated with improved control of routine illnesses that have serious consequences if left untreated. Availability of such services close to where the population reside improves patient satisfaction. Longitudinal care offered by primary care services reduces use of ancillary and laboratory services, leads to shorter lengths of stay at hospitals and improves patient compliance.

88. **While primary care services are largely associated with reducing burden of disease and at a low cost, there are welfare benefits that accrue to a household as a result of prevention of severe disease**. Severe disease can limit the ability of patients and care givers to work and lead to consumption of household assets in purchasing of care. Through prevention and early treatment, accessible primary care services can thus reduce consequences of ill-health for households, reduce absenteeism, and enhance children's performance at school.

89. The economic analysis for the Program compared the costs of the Program with the measurable benefits that arise from the implementation of the Program. Economic benefits of the Program are analyzed in terms of infant and maternal deaths averted as well as improved productivity and cost savings from lower future health care costs. It should be noted that this is an underestimate of the actual economic impact of the Program. Other benefits not quantified here include: poverty alleviation, psychological benefits of a healthy population and efficiency among current and future workers.

90. **In Tanzania, approximately half of infant deaths are among children in the neonatal age group (first month of life).** Among neonates, sepsis and respiratory distress are the leading causes of death and adequate care at birth or immediately after birth can significantly reduce mortality. Among post-neonates, malaria, pneumonia, dehydration due to diarrhea and underlying under nutrition are the leading causes of death. The Program supports strengthening of the PHC delivery system particularly maternal and child health and nutrition services nationwide.

91. **The economic analysis assumes that use of services will improve primarily due to improvements in quality of care (less drug stock outs, access to qualified health personnel) and the presence of more motivated staff that perform better as a result of the performance incentives and other interventions supported by the program**. In the economic analysis, the number of infant and maternal deaths that would be averted was simulated based on the following assumptions: (i) infant deaths, especially neonatal deaths, would be averted as institutional deliveries increase; (ii) improved care reduces the risk of acute respiratory infection (ARI) and malaria among post-neonates; (iii) as mothers receive PMTCT, the risk of HIV/AIDs among children is reduced; (iv) increase in coverage of quality antenatal care and institutional delivery followed by postnatal care would deter maternal deaths. Maternal and neonatal morbidity would also be reduced as women seek care and comply with the protocols (e.g. iron and folic acid supplementation for prevention of anemia and birth defects respectively). Subsequently, less women need to go for additional health care, resulting in savings in the cost of treatment and travel. Women's productivity too improves as their health status improves.

92. **As a result of the program, it is expected that as many as 1 million infant deaths and 84,000 maternal deaths will be averted over the period 2015-2035.** While the analysis focuses on infant and maternal deaths, many of these interventions would also reduce infant and maternal distress and morbidity. Consequently, total health benefits, as measured by a composite measure such as disability-adjusted life years would be significantly greater.

93. The Program reaches a positive net present value (NPV) by 2029; the net benefits accruing to the country are maximized thereafter. The internal rate of return (IRR) is positive but reaches the discount rate level by 2030 making the Program an acceptable investment.

94. A comprehensive economic analysis for the operation is outlined in Annex 4.

Technical risks

95. **By and large, the program design by the GOT is technically sound and risk of non-implementation of program activities is low given the fact that detailed implementation plans with time-bound actions, good division of labor, clear accountability and M&E mechanisms have been developed for all work streams under BRN in Health.** Some of the BRN in Health activities are already under implementation such as the "Star Rating" initiative. Although the limited capacity of program implementers remains a concern, the program's annual capacity building plans are expected to help address this issue.

96. **In summary, any residual risks related to technical design, implementation and M&E will be mitigated through the use of DLIs, program's annual capacity building as well as technical assistance to be financed through parallel financing from development partners**. These are summarized in Table 5.

Table 5: Technical Assessment: Key Risks and Mitigation Strategies

Risks	Mitigation
Technical Design	
Insufficient financing for the Program	- TA for HSSP IV costing and budgetary framework - TA for development of Health Financing Strategy - DLI 1 minimum condition on share of health in GOT's recurrent expenditures
New approaches (e.g. "Star Rating" accreditation, RBF) being implemented on a significant scale in Tanzania for the first time	- Careful pilots with assessments to improve the design - Impact evaluation of selected activities (e.g. RBF) to generate the evidence base for policy making - GOT's own mechanisms for adaptive implementation such as periodic BRN in Health check-ins; mid-term review of the HBF for fine-tuning as needed
High intensity of RBF activity	- Gradual roll-out
Program's imbalance between focus on processes and actual results	- Thorough analysis and stakeholder consultations to strike a balance between (i) key service delivery results and (ii) key bottlenecks in processes which need to be tackled to deliver such key service delivery results
Risk of non-implementation of certain Program activities	
Non-implementation due to poor planning	- Detailed implementation plans developed, with specific time-bound actions - DLI 1 minimum condition on improving planning at the council level
Non-implementation due to lack of accountability	- Accountability mechanisms for each level of implementers - Higher levels are also held accountable for results at the lower levels - DLIs to stimulate performance at every single level: national, regional, LGAs and PHC facilities
Non-implementation due to lack of capacity	- Detailed annual capacity building plans under the Program for all levels - DLI criteria related to the development and implementation of such plans - TA provided by development partners though parallel financing
Risks related to M&E	
HMIS does not produce quality data on a timely manner	- TA for DHIS-2 - GOT's plan on Data Quality Audit (DQA) by RHMTs for LGAs under the Program - DLI criterion related to (i) quality of HMIS data (ii) DQA

Lack of information on denominators in routine health statistics	- Civil registration and vital statistics (CRVS) initiative - Incentives for CHW and PHC facilities under RBF to fulfill their respective roles in CRVS

B. Fiduciary

97. A fiduciary systems assessment (FSA), which involves the assessment of governance and anti-corruption mechanisms, procurement and financial management systems for the Program was carried out in January 2015 in line with Operational Policy/Bank Procedure (OP/BP) 9.00, Program-for-Results Financing.[14] This assessment covered institutional and implementation arrangements, fiduciary management capacity and implementation performance, and also considered how existing systems handle the risks of fraud and corruption. The fiduciary systems' analysis was carried out at the LGAs and ministries, departments and agencies (MDA). The BRN in Health Lab report identifies some challenges such as incomplete reporting by the HMIS, insufficient data analysis capacity, under funding of the health sector, procurement bottlenecks, supply chain challenges, corruption and favoritism in health facilities, poor adherence to guidelines, erosion of MSD working capital and weak inventory control among others. These will be addressed under BRN by streamlining and improving the supply chain process, ensuring governance accountability at all levels, issuing performance targets and contracts, fiscal decentralization by devolution, strengthening financial management of medical store department (MSD), improving governance and accountability, use of ICT platforms, reducing pilferages, supporting funding for medicines, social accountability and implementation of health facility accreditation. The FSA concluded that the legal and regulatory framework for the program's fiduciary systems is comprehensive and in line with international principles and standards for public procurement and financial management, but there are no fiduciary systems in place at the facility level as they are not currently managing any financial and procurement activities.

98. **Financial management risks for the program have been assessed along different dimensions.** Key risks include timely transfer of funds from the Treasury to the LGAs and health facilities, late submission of reports, weak audit committees at the LGAs, challenges of the Epicor system, chart of accounts not able to track funds by individual source as well as lack of FM systems and staff at the health facilities. Other risks include weak accounting and internal audit staff skills especially at the LGAs in order to produce quality reports, accounts and conduct quality audits. The following measures would need to be implemented to address shortcomings: (i) strengthening audit committees in order to monitor how audit issues are being addressed; (ii) addressing the challenges faced by the Epicor system by revising the chart of accounts such that it can track funding from Development Partners; (iii) ensuring that discrepancies between funds transferred from treasury to LGAs and health facilities are eliminated through putting in place transparency measures such as displaying amounts transferred at both LGA and health facility levels; (iv) addressing the challenge of delays in receiving financial reports from the health facilities and

[14] The assessment covered the MOHSW, PMO-RALG, MSD, a sample of regional administrations, LGAs and PHC facilities. It also took into consideration the BRN healthcare NKRA Lab report; CAG's Report for LGAs and Central Government for FY13; Tanzania Public Expenditure and Financial Accountability (PEFA) reports for 2006, 2010 and 2013; Annual Performance Evaluation Report of the Public Procurement Regulatory Authority (PPRA); the Procurement and Value for Money Audit reports of selected LGAs and specific assessments done on MoHSW, PMORALG and MSD.

LGAs through appointment of accounting technicians and capacity building of the persons involved both at health facilities and councils. Furthermore, there will be need to strengthen auditing arrangements for health facilities, as it will be a challenge for CAG to audit them given the large number of health facilities involved in the program. This will be mitigated by contracting out the audit to private external audit firms acceptable to IDA.

99. **Procurement risks were also identified and mitigation measures suggested as part of the assessment.** There are legally established Tender Boards (TB) and project management units (PMUs) to manage the procurement functions, but in some LGAs, the TBs, have fewer members than required. Here PMUs operate as committees with only a few permanent staff while others are co-opted from other departments as needed. Procurement risks identified during the assessment include (i) inadequate staffing in LGAs; (ii) inadequate knowledge of - PPA 2011 and its regulations; planning, bidding documents and request for proposals preparation; and, evaluation of bids/proposals; (iii) inefficiencies in managing procurement processes; (iv) delays in vetting contracts above Tsh 50 million by the Attorney General; (v) weak record keeping and management systems; and, (vi) weak contract management. The following mitigation measures need to be considered both before as well as during program implementation to address the risks: (i) recruit/appoint qualified and experienced staff to fill the gap; (ii) conduct tailored trainings on PPA 2011 and its regulations to PMUs and internal audit units; (iii) establish sound records management systems in all LGAs and participating MDAs; (iv) ensure procurements are processed on a timely basis and that responsible unit play their respective roles as stipulated by PPA; (v) ensure that LGAs abide with all procedures for processing quotations including publications of contracts awards as per the PPA; (vi) review and uplift vetting thresholds; and, (viii) conduct tailor made training on contract management.

100. **Fraud and Corruption (F&C) risks have been identified and embedded as part of the broader fiduciary risks and mitigation measures**. In addition, the F&C assessment involved a review of the complaint handling mechanisms in the sector and how it could be strengthened to be used in the program for results. The GOT has committed to implementing the program within the Bank's Anti-Corruption Guidelines.

101. **Overall, the FSA concludes that the fiduciary risk is substantial**, but despite some weakness that have been identified and for which mitigation measures have been proposed, the Program fiduciary systems provide reasonable assurance that the financing proceeds under the Program will be used for intended purposes.

C. Environmental and Social Effects

102. **For environmental and social management, the PforR employs a risk management approach, in which process requirements are adapted to the program context.** The Environmental and Social Management System Assessment (ESSA) has been undertaken by the Bank to ensure consistency with six core principles outlined in the World Bank's *Operational Policy 9.00 - Program-for-Results Financing.*

103. **The ESSA process includes extensive stakeholder consultations and disclosure of the ESSA Report following the guidelines of the World Bank's Access to Information Policy.** The ESSA consultation process is embedded in the program consultation process.

104. **The program focuses on improving service delivery and strengthening systems and will also finance civil works related to upgrading and improving infrastructural conditions and utility services of the health facilities.** Program activities are not expected to have significantly adverse environmental footprint, if construction activities and healthcare facility operations are well managed. Impacts are also expected to be moderate since the infrastructure rehabilitation and construction works will be confined to existing PHC premises. The program provides an opportunity to improve due diligence measures related to management of construction related issues, good practices for asbestos management, improved healthcare waste management and incinerator operations, and enhancement of sanitation and water supply systems for monitoring and enforcement. Additionally, its programmatic approach to the health sector provides a significant opportunity to improve systemic implementation of environmental practices related to improving infection control practices and health systems functioning and operations at PHC facilities. These will be instituted through targeted resource allocations, including manpower, equipment and funds, updated technical guidelines, focused skills training and capacity building on technical and operational issues as part of the RBF and BRN in Health interventions.

105. **The program will also focus on enhancing existing mechanisms for grievance redress and dispute resolution, inclusive and participatory consultations and feedback for social accountability,** along with increasing awareness on environmental health issues and better coordination among various ministries, agencies and donor partners on environmental and social aspects.

106. **The ESSA identifies strengths, gaps and opportunities in Tanzania's environmental and social management system with respect to addressing the environmental and social risks associated with the program.** The analysis identifies the following main areas for action in order to ensure that the Program interventions are aligned with the core principles 1, 3 and 5 of OP/BP 9.00 applicable to the Program: health care waste management and social accountability. These could be further defined during implementation, as required. Key measures to strengthen system performance for environmental and social management are summarized in Annex 6 and selected actions will be included in the Program Action Plan.

107. **Key beneficiaries of the program are women of reproductive age and children under the ages of five; key program indicators will be monitored by gender.** The BRN in health, supported by the program, prioritizes regions with highest burden of maternal, neonatal, and child mortality. In addition, it aims to target and expand coverage of selected evidence-based interventions in RMNCAH that will have the greatest impact on lives saved through strong district level support in decision-making and implementation.

108. **Widespread shortages of qualified health workers, especially in rural and poor districts, result in the delivery low quality of primary care services to those most in need.** Redistribution of skilled personnel especially at the dispensary level with a focus on regions with critical shortages as planned under BRN HRH work stream and supported by the program is expected to further reduce inequities at the LGA level. The program also supports and incentivizes the new community health worker strategy bringing services closer to the population and promotes efficiency and health worker performance management through incentives, contracts and recognition, and provides opportunities for hiring of skilled HRH through PPP/private sector engagement.

109. **Grievance Redress.** Communities and individuals who believe that they are adversely affected as a result of a Bank supported PforR operation, as defined by the applicable policy and procedures, may submit complaints to the existing program grievance redress mechanism or the World Bank Group's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address pertinent concerns. Affected communities and individuals may submit their complaint to the World Bank 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 World Bank's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate Grievance Redress Service (GRS), please visit http://www.worldbank.org/GRS. For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.

D. Integrated Risk Assessment Summary

1. Integrated Risk Assessment Summary

Risk	**Rating**
Technical	Moderate
Fiduciary	Substantial
Environmental and Social	Moderate
Disbursement Linked Indicator	Moderate
Overall Risk	Substantial

2. Risk Rating Explanation

110. **Based on the integrated risk assessment carried out during preparation, the overall risk of the program is considered *substantial*** for the following reasons:

- Key elements of the program are associated with the current government. A new administration may not have the same level of commitment to it.
- Weak overall institutional capacity in the sector, particularly at the LGAs where the program will be implemented. This is particularly true given the responsibilities deriving from increased autonomy of health facilities in implementing service delivery improvements. Additionally, the regional level (RAS, RHMT) capacity to oversee, support and monitor LGAs to ensure compliance with national policies and service standards is limited.
- Concerns regarding the timely availability of resources to attain the DLIs, including the technical assistance required to support program implementation.
- Overall weak fiduciary arrangements, including frail control environment, insufficient staffing, poor contract management, record keeping and management system, and inadequate knowledge of the PPA 2011 and its Regulations.
- Insufficient institutional and technical capacity to handle environmental and social issues, including weak inter-institutional and coordination among various agencies, and inadequate formalized mechanism to address social and environmental issues.

111. Mitigation measures include: (i) mainstreaming the operation within existing institutional arrangements for fund flows and service delivery; (ii) implementing the Program's annual capacity building plan; and (iii) mobilizing technical assistance to fill any remaining gaps through parallel financing from development partners.

E. Program Action Plan

112. See detailed program action plan in Annex 8.

Annex 1: Detailed Program Description

A. Overview

1. Tanzania's Fourth Health Sector Strategic Plan 2015-2020 (HSSP IV) is the strategic and operational framework for health sector development over the next five years. PHC is a cornerstone of HSSP IV with a key initiative called Big Results Now in Health aimed at improving maternal, neonatal and child health.

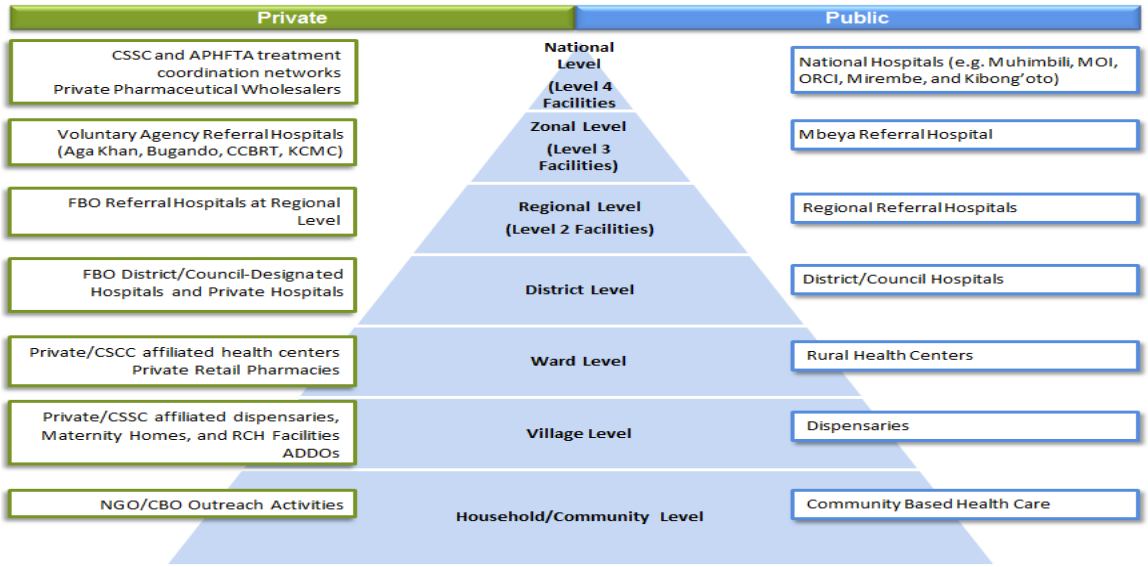
2. The program development objective is to improve the quality of primary health care (PHC) nationwide, with a focus on maternal, neonatal and child health. The program will support the Government's PHC as defined in HSSP IV (especially BRN in Health) by disbursing funds against the achievement of a subset of its key results in PHC, especially maternal, neonatal and child health.

B. Government's Program

3. Health sector development in Tanzania is guided by HSSP IV which forms a robust reform agenda for the coming years with the following objectives: (i) improve quality of care; (ii) revitalize PHC, including community-based services; and, (iii) increase affordability of health services.

4. In the structure of the Tanzanian health system, a basic package of essential PHC services is delivered at the district level and below by district hospitals, health centers, dispensaries and community based health services under the management of council health management teams (CHMT). Community-based health services bring health promotion and prevention to

Figure 3. The Healthcare Delivery System in Tanzania



the people in their communities. Dispensaries provide preventive and curative outpatient services, while health centres can also admit patients, and sometimes provide some surgical services.

District hospitals provide services which include curative and basic surgical services to referred patients from the lower levels.

5. In the context of HSSP IV, PHC will be revitalized by: (i) strengthening facility-based PHC services through initiatives to improve performance, HRH and commodities; (ii) establishing a new formal cadre of community based health workers to provide community-based health services; (iii) fostering the link between facility-based and community-based services to create a continuum of care; and (iv) improving LGA's health management services provided by the CHMT.

6. Efforts to strengthen PHC in Tanzania in HSSP IV will be operationalized by an initiative called Big Results Now in Health. The 2015-2018 Big Results Now in Health program has been developed as part of Tanzania's Development Vision 2025. It aims to accelerate the reduction of maternal and neonatal mortality through improving performance, governance and accountability in primary health care (PHC). It has four key result areas as follows:

- *Performance Management*: This result area aims to improve health facility and health workers' performance. Interventions include: (i) a stepwise accreditation scheme for all PHC facilities in the country (aka "Star Rating" initiative) which involves nation-wide assessment and a subsequent elaboration of facility improvement actions (including incentives) to help facilities improve their performances and star ratings, (ii) implementation of the decentralization by devolution policy by empowering health facilities to plan, budget and manage revenue in line with the health cost sharing guidelines that will increase health facility autonomy for improving quality of service delivery, (iii) setting and monitoring performance targets and contracts for personnel, and, (iv) mechanisms for social accountability monitoring.
- *Human Resources for Health*: This result area aims to improve the distribution of skilled PHC workers in nine regions with critical shortages in human resources for health (i.e. less than national averages). Interventions include: (i) increasing PHC employment permits for such regions, (ii) engaging the private sector to provide skilled HRH for public health facilities through public private partnerships (PPPs), (iii) redistributing health care workers within regions, and, (iv) optimizing the pool of new recruits through "bonding" policy or compulsory attachments.
- *Health Commodities*: This result area aims to improve the availability of essential medicines in PHC facilities. Interventions tackle key issues along the health commodities supply chain and include: (i) introducing new governance and accountability mechanisms, (ii) developing new finance and business model for MSD, (iii) engaging private sector in procurement and distribution, (iv) implementing quality improvement initiatives for inventory management, and, (v) use of innovative information and communication technology (ICT) to report stock-outs.
- *Maternal and Neonatal Child Health*: This result area aims to improve the coverage and quality of MNCH along the continuum of care in five regions that are poorly performing on maternal and neonatal mortality indicators. Interventions include: (i) ensuring dispensaries and health centers meet basic emergency obstetric and neonatal care (BEmONC) requirements, (ii) expanding comprehensive emergency obstetric and neonatal care (CEmONC) to selected hospitals and health centers, (iii) strengthening the corresponding satellite blood banks which serve facilities with CEmONC, and, (iv)

extending MNCH services to communities through the use of community health workers and awareness campaigns.

7. As a GFF front-runner country, the Government of Tanzania is developing a RMNACH investment case in line with its existing strategies and policies; namely BRN in Health, the Sharpened One Plan II and HSSP IV which were developed in a consultative and evidence-based manner. With a long term vision for RMNACH, this Investment Case identifies priorities for scaling up investments to accelerate the achievements of RMNACH goals. It is also built on the CRVS Strategy and the Health Financing Strategy[15]. As part of its development, extensive consultations with development partners, civil society and private sector have been conducted. This program supports the operationalization of this investment case as a critical step towards the realization of the GFF vision to end preventable maternal, newborn, child and adolescent deaths in Tanzania.

8. A core objective of the GFF is to support countries to harmonize RMNCAH financing and to move towards sustainability by harnessing domestic resources. In the case of Tanzania, the draft Health Financing Strategy encompasses several key strategies to realize the above vision, namely: (i) creating fiscal space through efficiencies; (ii) better defining functions of key actors in the sector including purchasers and providers of health services; and (iii) improving value for money with a pay-for-quality element in the planned capitation payment for PHC. The proposed program supports the government to operationalize such strategies and includes targets for improvements in (i) domestic financing for health; (ii) capacity of institutions involved in purchasing and provision; and (iii) value for money through the introduction and scale-up of performance-based financing at various levels.

9. Under HSSP IV, the Results-based Financing approach (RBF) will be introduced in at least 7 regions by 2019. Selection of regions for the first phase were based on socio-economic conditions and poor health maternal and child health outcomes. The focus will be on PHC facilities that will be paid based on the verified number of services provided and their quality. As a pre-condition to enroll in RBF, each facility will at least need to be rated with 1 star based on the BRN star-rating tool. Dispensaries and health centers with 1 star which do not rate 100% performance in the areas of equipment and infrastructure will be provided with a small readiness fund to make minor improvements. Facilities will be included as they are brought up to standard by the CHMT.

10. Dispensaries and health centers will enter into agreements with the RBF purchaser (the NHIF) in order to receive RBF payments based on the provision of under-utilized services (such as institutional deliveries, timely ante-natal and post-natal care visits as well as prevention of mother-to-child transmission of HIV) which are known to have an impact on RMNCAH outcomes. RBF payments for these services will be adjusted depending on the quality of care. Quality of care will be measured based on conditions to provide quality care (e.g. availability of essential supplies and equipment, water, infection control); patient care as registered on patient cards (e.g. partograph and neonatal care); system strengthening activities (such as number of new members enrolled in the Community Health Fund (CHF), a pre-payment scheme for rural populations); availability of quarterly technical and financial reports for RBF implementation); management and governance

[15] These two strategies are in an advanced stage of finalization and their endorsements by the Parliament are expected soon.

(e.g. Health Facility Governing Committee (HFGC) meetings held); and patient satisfaction. In district hospitals the RBF payment will be exclusively based on improving the quality of care. These RBF indicators are based on immediate needs and will change over time as the needs change. At the dispensaries and health centers, the number of services provided will be reported utilizing the existing health management information system (HMIS) which already reports on these services. Indicators linked to civil registration will be included as soon as they have been included in the HMIS system, as planned in the near future.

11. Based on the independent impact evaluation of the Pwani pilot (conducted between 2011 and 2013), promising results with significant positive effects on a range of incentivized services also highlighted the importance of including system strengthening measures, regional and council health management teams will also be paid based on their performance. Their RBF payment will be linked to relevant indicators (such as availability of tracer medicines in health facilities, supervision provided and star rating of health facilities linked to enrollment in to RBF). The Medical Stores Department (MSD) and their strategic business units (SBUs) will furthermore be paid based on their performance linked to indicators such as timely delivery of medicines to PHC facilities and ensuring appropriate expiry dates of the medicines. It was furthermore recognized that community health workers (CHWs) play an important role in the prevention and timely uptake of services, CHWs will therefore be paid based on their performance linked to three relevant RBF indicators (household visits, escorting of pregnant women to deliver at a health facility and the reporting of maternal and perinatal deaths which occurred outside the institutions). Lastly, learning from Pwani highlighted the importance of focusing significantly on improving the quality of care through RBF in the health facilities which will be pivotal to improve maternal and neonatal health outcomes.

12. RBF payments will be made to health facilities after verification by a team identified by RAS which consists of representatives of RHMT, the Regional NHIF office and civil society organizations (CSOs) to ensure transparency and prevent possible conflicts of interest. Following such verification, RBF payments will be made by the Ministry of Finance (MOF) directly into the bank accounts of the relevant providers based on their performance. In line with the fiscal decentralization, the providers of health and management services will be able to decide how to allocate the resources with at least 75% of the RBF payment to be invested in those activities (e.g. outreach or purchasing essential equipment) that will further improve performance and maximum 25% allocated to incentives for staff depending on their level of responsibility and attendance at work. Once a year, the Controller Auditor General Office (CAG) or the Internal Auditor General (IAG) will counter-verify the results on a sample basis (25%) and penalize the verification team if deemed necessary[16].

13. Governance and financial management is crucial, highlighting the importance of, for example, HFGC meetings at HF level as well as supervision and oversight by management at LGA level. The Prime Minister's Office - Regional Authority for Local Government (PMO-RALG) is also vital role as RBF facilitator to ensure local government authorities function effectively and by providing assistance, guidance and supervision to health facilities, councils and regional

[16] The RBF scheme thus has two mechanisms: (i) internal verification to trigger payments and (ii) counter-verification to trigger penalties if over-reporting is found. It should be noted that these two mechanisms are different from the verification mechanism for the DLIs.

secretariats. Technical assistance of the different institutions involved in RBF is furthermore vital. The upcoming public sector systems strengthening activity (PS3) of USAID will be beneficial as it will be implemented in 3 out of the seven RBF regions[17] and aims to strengthen the public system with a particular focus on strengthening the capacity of local government on matters such as planning, budgeting, financial management and the use of data for planning and monitoring. Furthermore, an assessment will be undertaken to identify additional activities and technical assistance needs of the institutions involved in the RBF implementation with a corresponding DLI. RBF is a national policy of the GoT and it is recognized that the speed of RBF roll out depends on availability of implementation capacity, human and financial resources.

14. The RBF payment is based on an additional amount of funding needed to improve performance at the different levels of the health systems - it is not based on the actual cost of delivering the service. A rapid assessment of health facility expenditures and staff motivation (including questions on proposed activities to improve performance and aspirational salary as reported by a sample of staff) was used to inform RBF needed incentive amounts - including both staff and non-staff incentives. The average per capita amount needed for RBF payments, verification and capacity building has been estimated at US$3.10 per capita/year. This excludes the RBF payments to the MSDs and an additional US$1.60 per capita for initial investment in equipment and infrastructure. It also assumes that ongoing support continues and RBF is additional.

15. RBF has been included in the health financing strategy of Tanzania; supporting a shift from input-based to more output-based financing. Existing resources for PHC (block grants, development partner financing and GoT sources) are envisioned to be reformulated using a resource allocation formula which combines per capita financing with RBF payments. Such an approach makes RBF sustainable and ensures a more predictable way of financing, with increased transparency/accountability and provider autonomy while linking results to financing.

16. In summary, PHC in HSSP IV (including BRN in Health) is the Government's program.

C. Scope of the Program and Typology of Program Activities

17. Time-wise and activity-wise, the five-year program to be supported by the PforR operation is the government's five-year program, namely the entire PHC component in HSSP IV (including BRN in Health). The rationale for this choice of program boundaries includes: (i) the close linkages of many PHC activities/initiatives under HSSP IV; (ii) the levels of World Bank's past engagement and added value; and (iii) the need to maintain a reasonable ratio of IDA financing vs. program's total cost. The program is based on the government program and there is thus no ambiguity over its boundaries.

18. The total cost of the program is US$2.62 billion or 55 percent of the GOT's health sector budget over the next five years. Figure 1 presents a results chain of the program, its activities and their linkages to program objectives. More information on program activities are also discussed in Annex 4 (Technical Assessment).

[17] Shinyanga, Mara and Kigoma

Table 6: The Government's Program Supported by the PforR Operation

	The GOT's program
Objective	Strengthen PHC quality
Expenditure categories	- Marginal cost for BRN in Health including Facility Based Incentives (RBF) - Salaries for PHC (Personnel emoluments) - Non-Salary operating cost for PHC - Capital investment in PHC - Procurement of drugs and medical supplies for PHC
Geographic scope	Nation-wide
Implementation period	2015-2020
Cost in US$	2.62 billion

Table 7: Program Expenditure Requirements in US$

PHC Initiatives	**Planned Expenditures in US$**					**Total**	**Percent**
	2015/16	**2016/17**	**2017/18**	**2018/19**	**2019/20**		
Personnel Emoluments	237,771,583	264,424,761	274,295,978	284,937,436	296,237,362	1,357,667,120	50.8%
Non-salary recurrent							
OC (block grant)	37,141,442	39,447,427	41,782,912	44,269,303	46,917,025	209,558,110	7.8%
other non-salary recurrent (HBF)	55,000,000	55,000,000	55,000,000	55,000,000	55,000,000	275,000,000	10.3%
Medicines	106,630,991	109,772,467	112,904,418	116,178,647	119,547,827	565,034,350	21.2%
Infrastructure	2,241,776	2,313,858	2,381,779	2,452,393	2,525,820	11,915,626	0.4%
BRN in Health							
Human Resources in Health	2,337,389	3,238,142	2,927,303			8,502,834	0.3%
Performance Management							
Accreditation, Social Accountability and Fiscal Decentralization	5,710,588	4,117,600	4,778,342			14,606,530	0.5%
Facility Based Incentives (RBF)	3,500,000	20,000,000	25,000,000	25,000,000	25,000,000	98,500,000	3.7%
Health Commodities	8,027,370	4,118,244	4,749,209			16,894,823	0.6%
MNCH	29,039,743	17,199,695	16,159,495			62,398,933	2.3%
	487,400,882	***519,632,195***	***539,979,436***	***527,837,779***	***545,228,035***	***2,620,078,326***	***100.0%***

Source: Budget data projections and BRN in Health costing data.

Table 8: Estimated Program expenditures by Administrative Units, US$

Administrative levels	Projected Allocations for 2015/16 to 2018/19						Total
	share	2015/16	2016/17	2017/18	2018/19	2019/20	US$
LGAs	90%	488,160,794	467,668,975	16,199,383	475,054,001	486,205,231	1,933,288,384
Regions	3%	16,272,026	15,588,966	12,797,122	15,835,133	16,206,841	76,700,089
PMO-RALG	1%	5,424,009	4,345,665	5,399,794	5,278,378	5,402,280	25,850,126
MOHSW	6%	32,544,053	112,987,302	32,398,766	31,670,267	32,413,682	242,014,070
Total, US$ millions	100%	***487,400,882***	***519,632,195***	***539,979,436***	***527,837,779***	***545,228,035***	***2,620,078,326***

19. Funding for the program under this operation includes (i) US$200 million in IDA credit, (ii) US$40 million in GFF grant, (iii) US$20 million in ANIS MDTF grant and (iv) a US$40 million in grant from USAID[18] through a single-donor Trust Fund arrangement. The total amount of the operation is therefore US$300 million, representing 11.5% of the total program cost. Other development partners will contribute US$290 million (or 11.1%) through parallel financing. The GOT will finance the remaining balance of US$2,030 million or 77.5% of the Program cost.

Table 9: Program Financing

Source	**Amount (US$ million)**	**% of total**
IDA	200	7.6%
GFF (co-financing)	40	1.5%
ANIS MDTF (co-financing)	20	0.8%
USAID TF (co-financing)	40	1.5%
Sub-Total	300	11.5%
Other development partners (parallel financing)	290	11.1%
Government	2,030	77.5%
Total Program Cost	2,620	100.0%

D. Institutional Arrangements for the Program

20. The Program's implementation will be based on the current institutional arrangements for the delivery of primary health care services i.e., the government program. In Tanzania, the MOHSW and the PMORALG are jointly responsible for ensuring achievement and verification of HSSP IV results and the specific outcomes of the BRN in Health implemented at the local level. Procurement and financial management under the program will be carried out by MOHSW and PMORALG for program activities for which they are respectively responsible. MOHSW and its subordinated agencies will be responsible for the program's compliance with environmental requirements. Both MOHSW and PMORALG have a role in addressing social aspects of the program.

[18] The USAID wingle donor TF is estimated at US$40 million.

21. The MOHSW, as the steward of the health system, is responsible for health policies, strategies, regulations, coordination and oversight for the sector and the Program. It leads the development of health sector strategic plans and the medium term expenditure framework for the sector on a rolling basis. The MTEF is the key document used in determining health sector budget allocations. The MOHSW provides oversight over autonomous and semi-autonomous national institutions responsible for key health sector functions such as the Medical Store Department (MSD), Tanzania Drug Authority (TFDA) and National Health Insurance Fund (NHIF) that are responsible for health commodities supply chain, food and medicine regulation and pre-paid health financing schemes.

22. PMORALG is responsible for coordinating, providing administrative support and allocating resources for the delivery of primary health services. PMORALG facilitates LGA to provide quality health services and manages the critical interfaces with MOF, MOHSW, DPs and LGAs. PMORALG monitors the support provided to local government authorities by regional secretariats (RS). PMORALG is also responsible for providing advice, information and capacity building to RS and LGAs policies, approaches, systems and planning methodologies.

23. As part of "Decentralisation by Devolution", local government authorities (LGAs) are responsible for delivering PHC as well as other public services. Funds for development and recurrent expenses are transferred from the Treasury to the LGAs, and from the LGAs to the health facilities. One of LGA's roles is to ensure proper accounting at the facility level. The Council Health Management Team (CHMT) manages district healthcare services and plays an important role in planning and decision-making at the LGA level. It reports to the District Council. The CCHP is the main document used by the council to negotiate funding with PMORALG and MOHSW. It will include health facility plans approved by Health Facility Governing Committees (HFGCs). The CHMT ensures that CCHP planning is inclusive, bringing on board all relevant actors in healthcare in the LGA. The CHMT helps build capacity and support Council Health Services Boards (CHSBs) and Health Facility Governing Committees (HFGCs) so that they are empowered to provide oversight over the activities of PHC facilities services and hold facilities accountable for results as well as for the use of resources.

24. At the regional level, the Regional Health Management Team (RHMT) works under the regional administration to supervise CHMT. It provides technical support to LGAs for the implementation of the Program, identify capacity building needs and monitor, supervise, and evaluate health services and conduct data quality audits. Both CHMT and RHMT are under PMORALG.

25. In line with Tanzania's decentralized health service delivery system, health facilities (public, faith-based and private) at the local government level deliver primary health care services. They will implement the program including the 22 BRN healthcare initiatives and the facility based incentive scheme i.e., the RBF in 7 regions in the first phase to improve quality of health services. Therefore, they play an important role in helping the Program to achieve its objectives.

26. The BRN in Health implementation focuses on PHC strengthening and therefore will be mainstreamed through MOHSW, PMORALG and LGA structures as described above. The PS-MOHSW along with the Permanent Secretary (PS) of PMORALG are members of the Health BRN's National Key Results Area (NKRA) Steering Committee. The MOHSW has established a

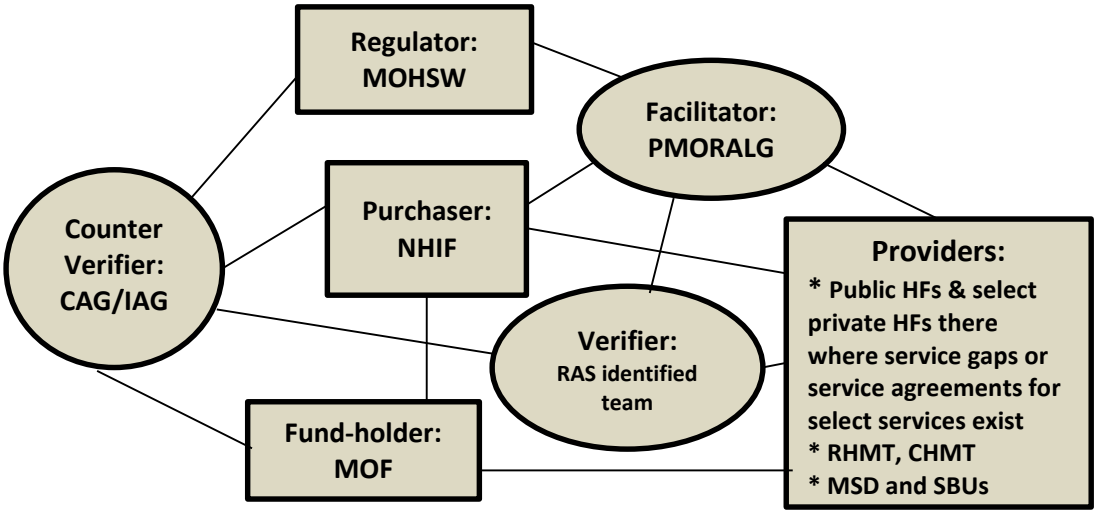
Ministerial Delivery Unit (MDU) for coordinating and monitoring the implementation of activities in the BRN in Health initiative. The MDU will ensure effective coordination and linkage between work streams supported by various Departments, sections, units and agencies.

27. The President's Delivery Bureau (PDB) oversees BRN in Health through collaboration with Prime Minister's Office, MOHSW and PMORALG. In the program delivery system, PDB is responsible for (i) problem solving and solution generation through providing feedback, advice and recommendations; (ii) facilitating the development of performance contracts of Ministers for MOHSW and PMORALG for purposes of accountability for results; and, (iii) reporting on progress/actions on BRN in Health implementation plans to the Transformation Delivery Council (TDC).

28. The implementation and institutional arrangements of the RBF (Figure 4) too has been mainstreamed into current government structures and are as follows:

- The regulatory role of developing policies, guiding documents and tools for RBF as well as providing clinical and technical oversight and supervision for RBF implementation will be the responsibility of the Ministry of Health and Social Welfare (MOHSW). In its department of Policy and Planning, a national RBF team has been established which oversees the implementation and roll out of RBF on a day-to-day basis.
- The National Health Insurance Fund (NHIF) as the largest public health insurer in Tanzania will carry out the role of purchaser. The NHIF will enter into agreements with providers of health and/or management services, of a specified quality.
- The providers of primary health care services consist of public health facilities (with at least 1 star rating) as well as select private health facilities (with 1 star or more) in those areas where service gaps exist or with whom service agreements are already in place for select services. Council and Regional Health Management Teams as well as Medical Stores Department (MSD) and their strategic business units (SBUs) will furthermore be paid based on their performance.
- To ensure the RBF payment will be based on accurate results, verification will be carried out prior to payment by a Regional Administrative Secretariat (RAS) identified team. This verification team will consist of RHMT members and include members of the regional NHIF office as well as civil society organizations to ensure transparency and prevent possible conflicts of interest. Once a year the Controller Auditor General Office will counter-verify the verified results on a sample basis and penalize the verification team if deemed necessary.
- The RBF payment will be made on a quarterly basis by the Ministry of Finance, as the so-called fund holder, directly into the relevant providers' bank account.
- The Prime Minister's Office - Regional Authority for Local Government (PMO-RALG) will play a vital role as facilitator to ensure local government authorities function effectively and by providing assistance, guidance and supervision to health facilities, councils and regional secretariats.

Figure 4: Institutional Arrangements for RBF



Annex 2: Results Framework

Program Development Objective: to improve quality of primary health care (PHC) nationwide with a focus on maternal, neonatal and child health (MNCH) services													
Indicators	**BRN**	**Core**	**DLI**	**Unit of Measure**	**Baseline**	**Target Values**					**Frequency**	**Data Source/Methodology**	**Responsibility for Data Collection**
						Yr. 1	**Yr. 2**	**Yr. 3**	**Yr. 4**	**Yr. 5**			
PDO Level Results Indicators													
PDO Indicator 1: PHC facilities with 3-Star ratings and above	■		■	%	0	10	15	25	35	50	Annual	Administrative data by the facility accreditation program	LGA
PDO Indicator 2: Pregnant women attending four or more ante-natal care (ANC) visits	■	■	■	%	41.2	45	49	53	57	60	Annual	Health Management Information System (HMIS)	LGA
PDO Indicator 3: ANC attendees receiving at least 2 doses of intermittent preventive treatment (IPT2) for malaria	■	■	■	%	42.52	45	49	53	57	60	Annual	HMIS	LGA
PDO Indicator 4: Institutional deliveries	■	■	■	%	44.72	48	51	54	57	60	Annual	HMIS	LGA
PDO Indicator 5: Proportion of children 12-59 months receiving at least one dose of Vitamin A supplementation during the previous year	■	■	■	%	51.00	53	55	57	61	65	Annual	HMIS	LGA

Intermediate Results Area 1: Health financing, public financial management													
Intermediate Results Indicator 1: Share of health in total government budget		■	■	%	8.5	8.75	9.0	9.2.5	9.5	9.75	Annual	Administrative data by MOF	MOF
Intermediate Results Indicator 2: Councils with unqualified opinion in the annual external audit report			■	%	80	82	84	86	88	90	Annual during program period	Administrative data by CAG	MOF
Intermediate Results Area 2: Performance Management													
Intermediate Results Indicator 4: Completion of "Star rating" assessment of PHC facilities as per the two-year cycle	■		■	%	(cycle 1 -0/ cycle 2 -0)	20/0	30/0	50/20	0/30	0/50	Annual during program period	Administrative data by the facility accreditation program	MOHSW
Intermediate Results Indicator 5: RBF facilities receiving timely RBF payment on the basis of verified results every quarter			■	%	0	75	80	85	90	95	Annual during program period	Administrative data by RBF program	MOF
Intermediate Results Indicator 6: LGAs with functional Council Health Service Boards			■	%	86.3	88	91	94	97	100	Annual during program period	Administrative data from CCHP report	LGA
Intermediate Results Area 3: Human Resource for Health (HRH)													
Intermediate Results Indicator 7: Annual employment permits for PHC given to the 9 critical regions	■		■	%	32	30	40	40	30	30	Annual during program period	Administrative data by BRN program	POPSM, MOHSW & PMORALG
Intermediate Results Indicator 8:	■		■	%	91	93	95	97	99	100	Annual during	Human Resources for Health	LGA

Dispensaries with skilled HRH											program period	information system (HRHIS)	
Intermediate Results Area 4: Supply chain management													
Intermediate Results Indicator 9: Health facilities with continuous availability of 10 tracer medicines in the past year	■	■	■	%	30.6	35	40	45	50	55	Annual during program period	Logistics Management Information System	LGA
Intermediate Results Area 5: RMNCAH continuum													
Intermediate Results Indicator 10: Health facilities with CEmOC	■			Number	79	91	104	104	104	104	Annual during program period	CCHP report and HMIS	LGA
Intermediate Results Area 6: M&E, supervision, and capacity building													
Intermediate Results Indicator 11: Completeness of quarterly HMIS data entered in DHIS by LGA (by the end of month after quarter ends)	■	■	■	%	89.5	91	92	93	94	95	Annual during program period	HMIS	MOHSW
Intermediate Results Indicator 12: RHMT's required biannual data quality audits (DQA) for LGAs that meets national DQA standards			■	%	0	50	60	70	80	90	Annual during program period	Administrative data by MOHSW and PMORALG	PMORALG
Intermediate Results Indicator 13: RHMT's required annual supportive supervision visits for LGAs that meets national supervision standards				%	0	50	60	70	80	90	Annual during program period	Administrative data by MOHSW and PMORALG	PMORALG

Intermediate Results Indicator 14: Completion of annual capacity building activities compared to agreed annual plans			■	%	N/A	90	90	90	90	90	Annual during program period	Administrative data by MOHSW and PMORALG	MOHSW & PMORALG

Annex 3: Disbursement Linked Indicators, Disbursement Arrangements and Verification Protocols

Table 10: Disbursement Linked Indicator Matrix

	Total financing allocated to DLI (US$ million)	Share in total financing amount (in percentage)	DLI Baseline	Indicative timeline for DLI achievement				
				Year or Period 1	Year or Period 2	Year or Period 3	Year or Period 4	Year or Period 5
DLI 1: Recipient has completed all foundational activities	20	6.7%	0%	X	X			
Allocated amount (US$ million):				10	10			
Definition/description of achievement: *This DLI consists of a set of 6 results related to preparation for capacity building, data quality improvement, fiscal decentralization, facility accreditation and MNCH readiness in five BRN regions to ensure a robust system-level framework for the Program. See Appendix 1 for details.*								
DLI 2: Recipient has achieved all of the Program annual results in institutional strengthening at all levels	75	25%	N/A	X	X	X	X	X
Allocated amount (US$ million):				15	15	15	15	15
Definition/description of achievement: *This DLI consists of 6 program annual results in institutional strengthening corresponding to specific sector bottlenecks: planning, budgeting, financial management, human resources for health and information on quality of care. All 6 conditions must be met each year. See Appendix 1 for details*								
DLI 3: PHC facilities have improved maternal, neonatal and child health services delivery and quality as per verified results and received payments on that basis each quarter	100	33.3%	0%	X	X	X	X	X
Allocated amount (US$ million):				5	20	25	25	25
Definition/description of achievement: *PHC facilities have completed the implementation of their quarterly RBF business plans. Internal verification has been carried out to verify the achievement of each PHC facility against an extensive list of facility level performance indicators. Facilities have received their incentive payments within 28 working days after the verification of results. See Appendix 1 for details.*								
DLI 4: LGAs have improved annual maternal, neonatal and child health service delivery and quality as measured by the LGA balance score card.	82	27.3%	0%		X	X	X	X

Allocated amount (US$ million):					20.5	20.5	20.5	20.5
Definition/description of achievement: *This DLI is assessed for each LGA using a LGA Balance Score Card which has 12 criteria related to MNCH service and systems performance (each with a different weight). See Appendix 1 for details.*								
DLI 5: Regions have improved annual performance in supporting PHC services as measured by a Regional Balance Score Card	2.4	0.8%	0%		X	X	X	X
Allocated amount (US$ million):					0.6	0.6	0.6	0.6
Definition/description of achievement: *This DLI is assessed by a Regional Balance Score Card with 2 criteria (each with a different weight) related to supportive supervision and data quality. See Appendix 1 for details.*								
DLI 6: MOHSW and PMORALG have improved PHC service performance as measured by the National Balance Score Card	5.6	1.9%	0%		X	X	X	X
Allocated amount (US$ million):					1.4	1.4	1.4	1.4
Definition/description of achievement: *This DLI is assessed annually by a National Balance Score Card with 4 criteria (each with different weight) related to (i) performance of LGAs (ii) performance of regions (iii) their support for lower levels and (iv) public finance management. See Appendix 1 for details.*								
DLI 7: Completion of annual capacity building activities at all levels	15	5%	0%		X	X	X	X
Allocated amount (US$ million):					3.75	3.75	3.75	3.75
Definition/description of achievement: *This DLI is assessed annually by the implementation rate of the annual Capacity Building Plan. This rate will be defined in accordance to a methodology set forth in the Program Operations Manual. Disbursement amount is $37,500 per 1 percent of Capacity Building Plan Implementation Rate.*								
Total Financing Allocated	**300***	**100%**		**30**	**68.75**	**67.25**	**67.25**	**66.75**

**This includes the USAID TF (estimated at US$40 million) as well as financing from GFF and ANIS MDTF*

Table 11: DLI Verification Protocol

No.	*Disbursement Linked Indicator*	*Scalability of Disbursements (Yes/No)*	*Protocol to evaluate achievement of the DLI and data/result verification**			
			Data source	*Data collection entity*	*Data verification entity*	*Verification procedures*
1	Recipient has completed all foundational activities	Yes	Government's routine information systems and reports	MoHSW & PMO-RALG	IAG	Review of deliverables (See Appendix 2 for more details)
2	Recipient has achieved all Program annual results in institutional strengthening	No	Government's routine information systems and reports	MoHSW & PMO-RALG	IAG	Review of deliverables (See Appendix 2 for more details)
3	PHC facilities have improved Maternal, Neonatal and Child Health service delivery and quality as per verified results and received payments on that basis each quarter	Yes	IFMIS and RBF administrative data	PMO-RALG	IAG/CAG	Review of quarterly RBF performance and payment report (See Appendix 2 for more details)
4	LGAs have improved annual Maternal, Neonatal and Child Health service delivery and quality as measured by the LGA Balance Score Card	Yes	DHIS 2 and other routine information systems	MoHSW & PMO-RALG	IAG	Annual review of relevant data from DHIS2 as well as other routine information system which are used to calculate BSC Annual verification field visit to spot check a random sample of 10% LGA, and 10% of facilities in each chosen LGA. Review will use standardized DQA tools

No.	*Disbursement Linked Indicator*	*Scalability of Disbursements (Yes/No)*	*Protocol to evaluate achievement of the DLI and data/result verification**			
			Data source	*Data collection entity*	*Data verification entity*	*Verification procedures*
						Review the calculation of LGA performance scores (See Appendix 2 for more details)
5	Regions have improved annual performance in supporting PHC as measured by Regional Balance Score Card	Yes	DHIS 2 and other routine information systems	MoHSW & PMO-RALG	IAG	Review of biannual DQA reports Review of quarterly RHMT supervision reports Review the calculation of regional performance scores (See Appendix 2 for more details)
6	MOHSW and PMO-RALG have improved performance in supporting PHC as measured by the National Balance Score Card	Yes	Routine information systems	MoHSW & PMO-RALG	IAG	Review relevant data from routine information systems to generate MoHSW and PMO-RALG performance scores Review the calculation of MoHSW and PMO-RALG performance scores (See Appendix 2 for more details)
7	Completion of annual institutional strengthening activities at all levels	Yes	Routine information systems	MoHSW and PMO-RALG	IAG	Annual review of capacity building report (See Appendix 2 for more details)

* Data will be submitted by MOHSW and PMO-RALG and checked by IAG (quarterly, bi-annual, or annual depending on the types of indicators). By October 31 each year, the GOT will submit the data for the prior FY data (July 1 – June 30) to IAG. Verification is to be completed by January 15 of the following year.

Table 12: Bank Disbursement

No.	*DLI*	*Bank financing allocated to the DLI (US$ million)*[19]	*Of which Financing available for*		*Deadline for DLI Achievement*	*Minimum DLI value to be achieved to trigger disbursements of Bank Financing*	*Maximum DLI value(s) expected to be achieved for Bank disbursements purpose*	*Determination of Financing Amount to be disbursed against achieved and verified DLI values*
			Prior results	*Advances*				
1	Recipient has completed all foundational activities	20	0	5	December 31, 2016	There are six results. Five results are valued at US$2 million while the sixth result is valued at US$10 million.	100%	Formula: Disbursement amount is US$2 million for each of the five results and US$10 million for sixth result. There are three activities within the sixth result with the following formulas: • US$2 million for completion of BEmONC and CEmONC assessment; • US$0.5 million for each health center meeting CEmONC standards, with total amount not exceeding US$ 4 million; and • US$57,143 for each 1% of health centers meeting BEmONC

[19] *This includes the USAID TF (estimated at US$40 million) as well as financing from GFF and ANIS MDTFs.*

								standards, with total amount not exceeding US$ 4 million
2	Recipient has achieved all of the Program annual results in institutional strengthening	75	0	0	February 15 every year	All of the program annual results have to be met to trigger disbursement (all-or-nothing)	N/A	Formula: Year 1: US$15 million Year 2 onward: US$15 million plus the undisbursed amount from the previous years, with the total annual disbursement not exceeding US$20 M
3	PHC facilities have improved MNCH service delivery and quality as per verified results and received payments on that basis each quarter	100 (includes USAID TF amount)	0	25	30 days after the end of each quarter	No minimum threshold	100%	Formula: Quarterly disbursement amount = (Sum of actual RBF payments in the past quarter) * 1.15
4	LGAs have improved annual MNCH service delivery and quality as measured by the LGA Balance Score Card	82	0	0	Every year, for Years 2, 3, 4 and 5	Annual average LGA BSC achievement is at least 30%	100%	Formula: Every year, disbursement only takes place when annual average LGA BSC achievement is at least 30%. Annual disbursement would be as follows: Year 2: US$341,667 for every 1 percentage point of achievement between 1% and 60%, US$387,500 for every 1 percentage point of achievement between 61% and 100% with total

								disbursement not exceeding US$36 M in Year 2 Year 3: US$292,857 for every 1 percentage point of achievement between 1% and 70%, US$516,667 for every 1 percentage point of achievement between 71% and 100%, with total disbursement not exceeding US$36 M in Year 3 Year 4: US$256,250 for every 1 percentage point of achievement between 1% and 80%, US$775,000 for every 1 percentage point of achievement between 81% and 100%, with total disbursement not exceeding US$36 M in Year 4 Year 5: US$227,778 for every 1 percentage point of achievement between 1% and 90%, US$1,550,000 for every 1 percentage point of achievement between 91% and 100%, with total disbursement not exceeding US$36 M in Year 5 Allocation to each LGA will then be a function of its

								performance score and a government equity formula[20]
5	Regions have improved annual performance in supporting PHC as measured by Regional Balance Score Card	2.4	0	0	Every year, for Years 2, 3, 4 and 5	No minimum threshold	100%	Formula: First, performance score for the past FY will be generated for each region, using the Regional BSC (expressed as %) Second, weighted average (by population) of regional scores in the past FY will be calculated Each year disbursement would be as follows: Year 2: US$10,000 for every 1 percentage point, with total disbursement not exceeding US$0.6 M in Year 2 Year 3: US$8,571 for every 1 percentage point, with total disbursement not exceeding US$0.6M in Year 3 Year 4: US$7,500 for every 1 percentage point, with total disbursement not exceeding US$0.6 M in Year 4

[20] The government's equity-based formula for the allocation of funds to LGAs will be the same as the one used for the Health Basket Fund and includes weighting by population, poverty, LGA BSC score and geographical constraints (to adjust for distances).

								Year 5: US$6,667 for every 1 percentage point, with total disbursement not exceeding US$0.6 M in Year 5 Allocation to each region will be a function of its performance score and population
6	MOHSW and PMO-RALG have improved PHC performance as measured by the National Balance Score Card	5.6	0	0	Every year, for Years 2, 3, 4 and 5	No minimum threshold	100%	First, performance score for the past FY will be generated for MOHSW and PMO-RALG, using the National BSC (expressed as %) Each year disbursement for MOHSW would be as follows: Year 2: US$23,333 for every 1 percentage point, with total disbursement not exceeding US$1.4 M in Year 2 Year 3: US$20,000 for every 1 percentage point, with total disbursement not exceeding US$1.4 M in Year 3 Year 4: US$17,500 for every 1 percentage point, with total disbursement not exceeding US$1.4 M in Year 4

								Year 5: US$15,556 for every 1 percentage point, with total disbursement not exceeding US$1.4 M in Year 5 Each year disbursement for PMO-RALG would be as follows: Year 2: US$3,333 for every 1 percentage point, with total disbursement not exceeding US$0.2 M in Year 2 Year 3: US$2,857 for every 1 percentage point, with total disbursement not exceeding US$0.2 M in Year 3 Year 4: US$2,500 for every 1 percentage point, with total disbursement not exceeding US$0.2 M in Year 4 Year 5: US$2,222 for every 1 percentage point, with total disbursement not exceeding US$0.2 M in Year 5
7	Completion of annual institutional strengthening activities at all levels	15	0	3.75	June 30 every year (for completion of activities the previous year)	No minimum threshold	100%	Each year the rate of implementation of the annual capacity building plan is calculated. This rate will be defined in accordance to a methodology set forth in the program operations manual.

								DLI allocation is US$37,500 per one percentage point of Capacity Building Plan implementation rate per year. Disbursement is once a year, when verified results are available
	TOTAL	300	0	33.75				

Appendix 1 to Annex 3: Methodology for Determining Each DLI Value

DLI 1: Recipient has completed all foundational activities

This DLI has six results. The first five are of equal value of US$2 million while the sixth one is valued at US$10 million (Table 13).

For results 1, 2, 3, 4, 5 and 6(a), disbursement is made on an all-or-nothing basis.

For result 6(b) and 6(c), disbursement formulas are:

- US$0.5 million for each health center meeting CEmONC standards, with total amount not exceeding US$4 million; and
- US$57,143 for each 1 percentage point of health centers meeting BEmONC standards, with total amount not exceeding US$4 million

For the DLI as a whole, disbursement can be considered to be on a sliding scale, given the facts that (i) non-achievement of a result does not prevent disbursement for the others and (ii) results 6(b) and 6(c) are scalable.

Table 13: DLI 1 – "Recipient has completed all foundational activities"

Result	Value
1. A 5-year capacity building plan for the program has been elaborated	2 million
2. Data quality audit tools prepared	2 million
3. Financial Instructions for health facility accounts prepared and disseminated to all LGAs	2 million
4. Verified baseline data (for 2014) and targets for performance indicators	2 million
5. List of operational health facilities and GPS locations prepared	2 million
6. RMNCAH-specific foundational activities a. Completion of BeMONC and CeMONC assessment in the five BRN RMNCAH regions (US$2 million) b. Eight selected health centers in the five BRN RMNCAH regions meeting CEMONC standards, (US$4 million) and, c. At least 70 percent of health centers in the five BRN RMNCAH regions meeting BeMONC standards (US$4 million).	10 million

DLI 2: Recipients have achieved all of the program annual results in institutional strengthening at all levels (national, regional, LGA and facilities)

This DLI has 6 results corresponding to program annual results in institutional strengthening which GOT needs to meet (Table 14). Annual disbursement takes place when all 6 results have been met. Disbursement amount is as follows:

Year 1: US$15 million
Year 2 onward: US$15 million plus the undisbursed amount from the previous years, with the total annual disbursement not exceeding US$20 million.

Table 14: DLI 2 – "Recipients have achieved all of the Program annual results in institutional strengthening at all levels" (national, regional, LGA and facilities)

Results
1. Share of health in total government budget
2. Percentage of council whose annual comprehensive Council Health Plan (CCHP) passes the first round of assessment
3. Action Plans of Audits of PMORALG and MOHSW received within 2 months of the official release of the Controller and Auditor General (CAG) report
4. Percentage of PHC facilities with bank accounts opened according to guidelines from Ministry of Finance (MoF)/CAG (BRNH indicator)
5. Share of total annual employment permits for PHC given to the 9 critical regions (BRNH indicator)
6. Percentage of completion of "Star rating" assessment of PHC facilities (BRNH indicator)

DLI 3: PHC facilities have improved maternal, neonatal and child health service delivery and quality as per verified results and received payments on that basis each quarter

The RBF scheme provided incentives for each PHC facility on the basis of quantity and quality of services as follows:

Step 1. For quantity of care, there is a list of specific services, each has a different unit cost. Every quarter, through internal verification of results, quantity payment (A) for each facility in the scheme is calculated on the basis of number of services the facility provided and unit costs.

Step 2. For quality of care, a quality of care assessment is carried out for each facility in the scheme each quarter. The result is expressed in percentage (B)

Step 3. Final quarterly performance-based payment for each facility = A*B

Quarterly disbursement amount for DLI 3 = sum of actual RBF incentive payments in the past quarter X 1.15

(*The 1.15 coefficient takes into account the cost of administration and verification of the RBF scheme*)

DLI 4: LGAs have improved annual maternal, neonatal and child health service delivery and quality as measured by the LGA Balance Score Card

DLI 4 represents annual performance in MNCH service delivery at the LGA level. Such performance is assessed annually for each LGA, using a LGA Balance Score Card (BSC). The BSC has 12 criteria , the majority of them being the GOT's own indicators (either from BRN in Health or RMNCAH scorecard which quarterly monitors LGA level performance on maternal and child health indicators and reports to the President's office). The 12 criteria, broadly speaking, can

be categorized in two groups: (i) six criteria related to "maternal, neonatal and child health service delivery outputs" and (ii) six criteria related to "improving conditions for quality of care"

Table 15: DLI 4 – "LGAs have improved annual MNCH service delivery and quality as measured by the LGA Balance Score Card"

Weights, Baseline and Annual Targets for Each Performance Criterion in the BSC

Results	Score	National Baseline	Y1	Y2	Y3	Y4	Y5
Maternal, Neonatal and Child Health Service Delivery Outputs (6 Criteria, Subtotal Score: 50)							
1. Percentage of pregnant women attending four or more antenatal care visits (ANC4)	10	42.1%	45%	49%	53%	57%	60%
2. Percentage of ANC attendees receiving at least 2 doses of intermittent preventive treatment (IPT2) for malaria	7	42.5%	45%	49%	53%	57%	60%
3. Percentage of ANC attendees receiving adequate quantity of iron and folic acid tablets until next ANC visit	5	50.2%	53%	56%	59%	62%	65%
4. Percentage of institutional deliveries	13	44.7%	48%	51%	54%	57%	60%
5. Percentage of women of reproductive age using modern family planning methods	10	37.3%	38%	39%	40%	41%	42%
6. Children 12-59 months receiving at least one dose of Vitamin A supplementation during the past year	5	51.0%	53%	55%	57%	61%	65%
Improving Conditions for Quality of Care (6 Criteria, Subtotal Score: 50)							
7. Percent of PHC facilities with "3 stars" rating or higher	15	7.0%	10%	15%	25%	35%	50%
8. Percent of dispensaries with skilled HRH	10	91.0%	93%	95%	97%	99%	100%
9. Percentage of PHC facilities with continuous availability of 10 tracer medicines in the past year	10	30.6%	35%	40%	45%	50%	55%
10. Percentage of LGAs with functional Council Health Service Boards	5	86.3%	88%	91%	94%	97%	100%
11. Percentage of completeness of quarterly DHIS 2 entry by LGA (by Day 30 after the end of each quarter)	5	89.5%	91%	92%	93%	94%	95%
12. Percentage of LGAs with unqualified opinion in the external audit report	5	80.0%	85%	90%	95%	100%	100%
TOTAL	100						

- Each of the 12 criteria in the LGA BSC has a different scores (depending on the level of importance of the criterion and effort needed to achieve the result)
- The total score for the 12 criteria in the LGA BSC is 100.
- For each criterion, a national baseline is established in order to help set national targets for Year 2, 3, 4 and 5, using recommended methodologies.[21]
- A baseline is also established for each criterion for each LGA. The score for each criterion is then prorated between LGA baseline and the national target. Thus in terms of performance, a LGA is assessed against its own baseline and given a prorated score accordingly
- The level of performance of this year will serve as baseline for the next year)
- If an LGA exceeds the target for a certain criterion, additional pro-rated score will be given. This is to allow an implementer to make up for other criteria in the BSC which it may underperform. All the pro-rated scores will then be added up to get the total score for each LGA. However, there is a cap of 100 for the maximum score a LGA can earn in a year..
- Below is an example of how a pro-rated score is calculated according to the level of the achievement of a criterion in the LGA BSC.

    - ✓ For criterion No.1 in the BSC (percentage of pregnant women attending four or more antenatal care visits or ANC 4), the assigned score is 10.
    - ✓ On the basis of the national baseline value for this criterion (42%) the national target for year 1 is set at 45%.
    - ✓ As an illustration, for a certain LGA, its own baseline for the criterion is 35%. The prorated score for every one percentage point increase in ANC 4 for that particular LGA is then 10/(45-35)=1
    - ✓ If the LGA achieves a result of 43% for this criterion, its pro-rated score would be: (43-35)*1=8
    - ✓ If the LGA achieves a result of 46% for this criterion, its pro-rated score would be: (46-33)*1= 11

- For LGAs which outperform the national target in one year and then stay the same the following year in a criterion, its score for that criterion will be calculated by comparing their performances against the national target in the previous year (instead of against their own performances in the previous year)
- After the annual BSC score has been generated for each LGA, the aggregate LGA BSC score for that year will be calculated as the national average (weighed by population) of LGA scores. This LGA BSC score will then be used to calculate DLI 4 disbursement amount as per formula in Annex 3.

Every year, disbursement only takes place when annual average LGA BSC achievement is at least 30%.

[21] *Arur, Aneesa; Mohammed-Roberts, Rianna; Bos, Eduard. 2011.* Setting Targets in Health, Nutrition and Population projects. *World Bank, Washington, DC. © World Bank. https://openknowledge.worldbank.org/handle/10986/13587*

Annual disbursement amount for DLI 4 would be calculated as follows:

Year 2: US$341,667 for every 1 percentage point of achievement between 1% and 60%, US$ 387,500 for every 1 percentage point of achievement between 61% and 100% with total disbursement not exceeding US$36 M in Year 2

Year 3: US$292,857 for every 1 percentage point of achievement between 1% and 70%, US$ 516,667 for every 1 percentage point of achievement between 71% and 100%, with total disbursement not exceeding US$36 M in Year 3

Year 4: US$256,250 for every 1 percentage point of achievement between 1% and 80%, US$ 775,000 for every 1 percentage point of achievement between 81% and 100%, with total disbursement not exceeding US$36 M in Year 4

Year 5: US$227,778 for every 1 percentage point of achievement between 1% and 90%, US$1,550,000 for every 1 percentage point of achievement between 91% and 100%, with total disbursement not exceeding US$36 M in Year 5

Once disbursement has been made for DLI4, Government will divide the funds among LGAs taking into account (i) individual LGA BSC scores (ii) government's equity formula. The equity based formula for the allocation of funds to LGAs will be the same as the one used for the Health Basket Fund and includes weighting by population, poverty, LGA BSC score and geographical constraints (to adjust for distances).

DLI 5: Regions have improved annual performance in supporting PHC as measured by Regional Balance Score Card

DLI 5 represents annual performance in supporting PHC services at regional level. Such performance is assessed annually for each region, using a Regional Balance Score Card (BSC). The BSC has 2 criteria related to supportive supervision and data quality audit by RHMT for LGA. Each criterion has a different weight (according to level of importance and difficulty). Disbursement for this DLI is made annually and on a sliding scale basis.

Table 16: DLI 5 – "Regions have improved annual performance in supporting PHC as measured by Regional Balance Score Card"

Results	Score	How the scores are calculated in the BSC
1. RHMT's required biannual data quality audits (DQA) for LGAs that meets national DQA standards	40	0.4 score for every 1% of biannual data quality audits (DQA) for LGAs that meets national DQA standards
2. RHMT's required annual supportive supervision visits for LGAs that meets national supervision standards	60	0.6 score for every 1% of required annual supportive supervision visits for LGAs that meets national supervision standards
TOTAL	**100**	

First of all, performance score for the past FY will be generated for each region, using the regional BSC (expressed as %). On this basis, weighted average (by population) of regional scores in the past FY will be calculated.

Annual disbursement amount for DLI 5 would be calculated as follows:

Year 2: US$10,000 for every 1 percentage point, with total disbursement not exceeding US$0.6 M in Year 2

Year 3: US$8,571 for every 1 percentage point, with total disbursement not exceeding US$0.6M in Year 3

Year 4: US$7,500 for every 1 percentage point, with total disbursement not exceeding US$0.6 M in Year 4

Year 5: US$6,667 for every 1 percentage point, with total disbursement not exceeding US$0.6 M in Year 5

Allocation to each region will be a function of its performance score and population.

DLI 6. MOHSW and PMO-RALG have improved PHC service performance as measured by the National Balance Score Card

DLI 6 represents annual performance by MOHSW and PMO-RALG in support of PHC services at the local level. Their performance will be assessed annually a National Balance Score Card with four criteria. With this BSC, national implementers will thus be held accountable for the performance in PHC service delivery at the lower levels. Each criteria is given a different weight according to its level of importance and difficulty. Disbursement for this DLI will be made annually and on a sliding scale basis.

Table 17: DLI 6 – "Program implementers have achieved annual PHC results at the national level"

Results	Score		How the scores are calculated in the BSC
	MOHSW	PMO-RALG	
1. Average and variance of LGA performance scores (derived from DLI 4) Formula: Composite national LGA score = Population-weighted average LGA score * (1 – 1 Standard Deviation)	30	50	MOHSW receives 0.3 score for every composite national LGA score PMO-RLAG receives 0.5 score for every composite national LGA score

2. Average of regional performance scores (derived from DLI 5)	40	30	MOHSW receives 0.4 score for every average regional score PMO-RLAG receives 0.3 score for every average national LGA score
3. Percentage of unsupported expenditures in MOHSW/PMO-RALG in their annual audits	20	20	Each ministry receives 0.2 score for every one percent of supported expenditure
4. Percentage of LGA's receiving CHF matching funds	10	0	MOH receives 0.1 score for every one percent of LGA's receiving CHF matching funds
TOTAL	**100**	**100**	

Performance scores for the past FY will be generated for MOHSW and PMO-RALG, using the National BSC (expressed as %) as defined in Table 17.

Annual disbursement amount for MOHSW will be calculated as follows:

Year 2: US$20,000 for every 1 percentage point, with total disbursement not exceeding US$1.2 M in Year 2

Year 3: US$17,143 for every 1 percentage point, with total disbursement not exceeding US$1.2 M in Year 3

Year 4: US$15,000 for every 1 percentage point, with total disbursement not exceeding US$1.2 M in Year 4

Year 5: US$13,333 for every 1 percentage point, with total disbursement not exceeding US$1.2 M in Year 5

Annual disbursement amount for PMO-RALG will be calculated as follows:

Year 2: US$3,333 for every 1 percentage point, with total disbursement not exceeding US$0.2 M in Year 2

Year 3: US$2,857 for every 1 percentage point, with total disbursement not exceeding US$0.2 M in Year 3

Year 4: US$2,500 for every 1 percentage point, with total disbursement not exceeding US$0.2 M in Year 4

Year 5: US$2,222 for every 1 percentage point, with total disbursement not exceeding US$0.2 M in Year 5

DLI 7. Completion of annual capacity building activities at all levels

Under the foundation activities in DLI 1, the GOT will prepare a 5-year capacity building plan related to PHC at all levels. The plan will be reviewed and agreed each year between the GOT and IDA. This DLI represents the percentage of activities completed in the agreed plan in the previous fiscal year. Disbursement for this DLI will be made annually and on a sliding scale basis.

Each year the rate of implementation of the annual capacity building plan will calculated. This rate will be defined in accordance to a methodology set forth in the program operations manual.

Annual DLI 7 amount = US$37,500 per one percentage point of capacity building plan implementation rate

Appendix 2 to Annex 3

Independent Verification of Program Results

Scope of Work for IAG

A. Overview

1. The Internal Auditor General (IAG) and has been designated as the independent verification agency by the GOT in this PforR operation. Using GOT's procurement procedures, IAG can contract other eligible entities to help with verification provided that such entities are independent from the program implementers to avoid any conflict of interests. In such a case, IAG is still ultimately responsible for the verification and needs to sign off on the verification reports.

B. Objective

2. IAG will carry out independent verification of results related to the disbursement linked indicators which are reported in the government's performance assessment to ensure its quality, independence, accuracy, and robustness.

C. Scope of Work Overview[22]

No.	*DLIs and Corresponding Results*	*Protocol to evaluate achievement of the DLI and data/result verification**		
		Data source	*Data collection entity*	*Verification procedure*
1.	**Recipient has completed all foundational activities**			
1.1.	A 5-year capacity building plan for the Program has been elaborated	Plan	MoHSW & PMO-RALG	- Five-year capacity building plan acceptable to the World Bank
1.2.	Data Quality Audit (DQA) tools prepared and field tested	Tools and field testing report	MoHSW & PMO-RALG	- Final data quality audit (DQA) tools and field-testing report acceptable to the World Bank
1.3.	Financial Management (FM) manual for health facility accounts prepared and disseminated to all LGAs	Manual and dissemination report	PMO-RALG,	- Final FM manual for health facility accounts acceptable to the World Bank - Dissemination report acceptable to the World Bank

[22] It should be noted that counter-verifications in the RBF scheme is separate from verifications for the DLIs. The TORs for counter-verifications in the RBF scheme will be elaborated in the POM.

No.	*DLIs and Corresponding Results*	*Protocol to evaluate achievement of the DLI and data/result verification**		
		Data source	*Data collection entity*	*Verification procedure*
1.4.	Verified baseline data (for 2014) and targets for performance indicators	HMIS, medical records and registries	MoHSW & PMO-RALG	- Independent verification agency conducts verification of baseline data for all LGAs, using protocols acceptable to the World Bank
1.5.	List of health facilities and GPS locations prepared	Health facility mapping survey	MoHSW & PMO-RALG	- List of health facilities with GPS coordinates acceptable to the World Bank
1.6.	6. (a) Completion of BeMONC and CeMONC assessment in the five BRN RMNCAH regions (b) Eight selected health centers in the five BRN RMNCAH regions meeting CEMONC standards, and, (c) At least 70 percent of health centers in the five BRN RMNCAH regions meeting BeMONC standards	Spot check	MoHSW & PMO-RALG	- BeMONC and CeMONC assessment report of the five BRN RMNCAH regions - Proof of 8 health facilities which in the assessment failed to meet CEmONC standards now up to CEmONC standards - Proof of 70% of health centers in the five BRN RMNCAH regions meeting BEmONC standards
2	**Recipient has achieved all of the program annual minimum conditions in institutional strengthening at all levels (national, regional, LGA and facilities)**			
2.1	Percentage of health in government budget	Admin data (IFMIS)	MoF	- Annual Budget Book approved by the Parliament
2.2	Percentage of councils whose annual CCHPs pass in the first round of assessment	CCHPs Admin data	PMORALG	- Annual review of CCHPs and RAS admin data and records
2.3	Percentage of "Star Rating" assessment of PHC facilities completed	Facility accreditation assessment report	MoHSW & PMO-RALG	- Review of annual facility accreditation assessment report

No.	*DLIs and Corresponding Results*	*Protocol to evaluate achievement of the DLI and data/result verification**		
		Data source	*Data collection entity*	*Verification procedure*
2.4	Percentage of annual employment permits for HRH in PHC given to the nine critical regions	Admin data/ HRHIS	MoHSW	- Annual review of employment permits
2.5	Action Plans of Audits of recipients of HBF received within 2 months of official release of the CAG report	Audit action plans	MoHSW & PMO-RALG	- Annual review of action plans
2.6	Percentage of PHC facilities with bank accounts opened according to guidelines from MOF/Accountant General	IFMIS	MoHSW & PMO-RALG	- Review of list of facilities bank accounts maintained by the Accountant General
3.	**PHC facilities have improved Maternal, Neonatal and Child Health service delivery and quality as per verified results and received payments on that basis each quarter**			
	Percentage of PHC facilities in the RBF scheme receiving quarterly performance-based incentives within 21 days after results have been verified	Admin Data/ IFMIS	NHIF	- Quarterly review of RBF verification and payment reports
4	**LGAs have improved annual maternal, neonatal and child health service delivery and quality as measured by the LGA Balance Score Card**			
4.1	Percentage of pregnant women attending four or more antenatal care visits (ANC4)	HMIS	MoHSW	- Annual review of HMIS - Annual verification field visit to spot check a random sample of 10% LGA, and 10% of facilities in each chosen LGA. Review will use standardized DQA tools
4.2	Percentage of ANC attendees receiving at least 2 doses of intermittent preventive treatment (IPT2) for malaria			

No.	*DLIs and Corresponding Results*	*Protocol to evaluate achievement of the DLI and data/result verification**		
		Data source	*Data collection entity*	*Verification procedure*
4.3	Percentage of ANC attendees receiving adequate quantity of iron and folate tablets until next ANC visit			
4.4	Percentage of institutional deliveries			
4.5	Percentage of women of reproductive age using modern family planning methods			
4.6	Children 12-59 months receiving at least one dose of vitamin A supplementation during the previous twelve months			
4.7	Percent of PHC facilities with "3 star" rating or higher	Facility accreditation assessment report	MoHSW & PMO-RALG	- Annual review of facility accreditation assessment report - Spot check for a random sample of PHC facilities as part of annual verification field visit (described for DLIs 4.1-4.6)
4.8	Percent of dispensaries with skilled HRH	HRHIS	MoHSW & PMO-RALG	- Annual review of HRHIS - Spot check for a random sample of PHC facilities as part of annual verification field visit (described for DLIs 4.1-4.6)
4.9	Percentage of PHC facilities with continuous availability of 10 tracer medicines in the past year	LMIS	MoHSW & PMO-RALG	- Annual review of LMIS - Spot check for a random sample of PHC facilities as part of annual verification field visit (described for DLI 4 criteria 4-6)
4.10	Percentage of LGAs with functional Council Health Service Boards	Admin data	PMO-RALG	- Annual review of admin data - Spot check for a random sample of LGA facilities as part of annual verification field visit

No.	*DLIs and Corresponding Results*	*Protocol to evaluate achievement of the DLI and data/result verification**		
		Data source	*Data collection entity*	*Verification procedure*
4.11	Percentage of completeness of quarterly DHIS 2 entry by LGA (by Day 30 after the end of each quarter)	HMIS	MoHSW	- Annual review of HMIS - Spot check for a random sample of LGA facilities as part of annual verification field visit
4.12	Percentage of LGAs with unqualified opinion in the external audit report	Audit reports	PMO-RALG	- Annual review of all external audit reports
5	**Regions have improved annual performance in supporting PHC services as measured by Regional Balance Score Card**			
5.1	RHMT's required biannual data quality audits (DQA) for LGAs that meets national DQA standards	Admin data	MoHSW & PMORALG	- Review of biannual DQA reports
5.2	RHMT's required quarterly supportive supervision visits for LGAs that meets national supervision standards	RHMT supervision reports	MoHSW & PMORALG	- Review of quarterly RHMT supervision reports
6	**MOHSW and PMO-RALG have improved annual PHC service performance as measured by the National Balance Score Card**			
6.1	Average of LGA performance scores	Admin data	MoHSW & PMORALG	- Annual review LGA performance data
6.2	Variance in LGA performance scores	Admin data	MoHSW & PMORALG	- Annual review LGA performance data
6.3	Percentage of unsupported expenditure in MoHSW/ PMORALG audits	IFMIS and Audit	MoHSW & PMORALG	- Annual review of IFMIS and audit reports
6.4	Percentage of LGAs receiving CHF matching grants	IFMIS	MoHSW & PMORALG	- Annual review of IFMIS

No.	*DLIs and Corresponding Results*	*Protocol to evaluate achievement of the DLI and data/result verification**		
		Data source	*Data collection entity*	*Verification procedure*
7	**Completion of annual capacity building activities at all levels**			
	Completion of annual capacity building activities as per agreed annual plans	Capacity building report	MoHSW & PMORALG	- Annual review of capacity building report

Annex 4: Technical Assessment Summary

A. Strategic Relevance and Technical Soundness of the Proposed Program

A.1 Strategic relevance

1. Over the last 10 years, in Tanzania, progress has been made in reducing death rates in younger age groups and improving coverage of selected high impact interventions. Tanzania has also made significant strides in improving immunization coverage and surpassing the Millennium Development Goal for reducing child mortality. Between 1999 and 2010, infant mortality fell from 99 per 1,000 live births to 51 per 1,000 live births respectively, while under-5 mortality declined from 147 to 81 per 1,000 live births (Tanzania Demographic Health Survey (TDHS), 2010). A 2008 Lancet article on child survival gains in Tanzania[23] attributed a large proportion of these improvements to investments in health systems and scaling up specific interventions through a decentralized approach. These include an increased proportion of children under five years of age sleeping under bed nets (from 36.3 percent in 2007/8 to 72.6 percent in 2009/10), increased vaccination coverage, vitamin A supplementation, and improved functioning of Integrated Management of Childhood Illness (IMCI) at the facility and community levels.

2. However, progress in reduction of maternal mortality and neonatal mortality has been slow. Maternal mortality ratio remains high at 410 per 100,000 live births (UN Estimates 2013) against a backdrop of low facility deliveries and family planning coverage. Neonatal mortality rate is 21 per 1,000 live births according to 2013 United Nations estimates. There is also a persistently high level of stunting (42 percent among children under five years of age), affecting over 3 million children. Overall, communicable, maternal, neonatal, and nutritional causes remain the major burden of mortality and illness for the population (Table 18).

Table 18: Top Causes of Life Years Lost (YLLs) in Tanzania

Rank and disorder 2010	# YLLS in thousand dollars (% of total)
1. HIV/AIDS	4,503 (20.6%)
2. Malaria	3,068 (13.9%)
3. Lower respiratory infections	2,000 (9.2%)
4. Diarrheal diseases	930 (4.3%)
5. Neonatal encephalopathy	851 (3.9%)
6. Preterm birth complications	812 (3.7%)
7. Protein-energy malnutrition	676 (3.1%)
8. Neonatal sepsis	636 (2.9%)
9. Syphilis	615 (2.8%)
10. Road injury	512 (2.3%)
11. Tuberculosis	501 (2.3%)
12. Maternal disorders	491 (2.3%)

Source: Institute for Health Metrics and Evaluation 2013.

[23] Masanja, H., et al, *Child Survival Gains in Tanzania: Analysis of Data from Demographic and Health Surveys,* The Lancet, 2008; 371: 1276–83.

3. Without effectively improving the health of the nation, Tanzania will not be able to materialize the aspirations of the Tanzanian Development Vision 2025 and reduce health-related economic costs. Currently, US$431 million is being spent on treatment every year; an estimated GDP loss of US$272.6 million occurs annually due to the common diseases affecting the working population alone. Such numbers are expected to rise.

4. In this context, there is a consensus that health is important to economic development and poverty reduction in Tanzania. It has been identified as a priority in (i) the Government's Tanzania Development Vision 2025 (launched in 1999), (ii) the National Strategy for Growth and Poverty Reduction 2010-2015 (MKUKUTA II); and (iii) the World Bank's Country Assistance Strategy 2012-2015.

Table 19: Tanzania's Health Outcomes and Health Expenditures

	Tanzania[1]		Sub-Saharan Africa[2]
Outcome Indicators	**2005**	**2010**	**2013**
Under 5 mortality rate per 1,000 live births	112	45[3]	92.4
Infant mortality rate per 1,000 live births	68	51	61
Maternal mortality ratio per 100,000 live births	578	432[3]	510
Total fertility rate (children per woman)	5.7	5.2[3]	5.1
Stunting (Height for Age <-2SD, %)	38	42	37
Underweight (Weight for Age <-2SD, %)	22	16	21
Wasting (Weight for Height <-2SD, %)	3	5	9
Service Coverage Indicators			
Skilled birth attendance (% of pregnant women)	47	51	50
Contraceptive prevalence rate (% of women ages 15-49 years)	20	27	24
Full immunization coverage (% of children aged 12-23 months)	71	75	
Children who slept under an ITN last night (% of under-5 children)	16	64	35.2
Women who slept under an ITN last night (% of pregnant women)	16	57	
Health Financing Indicators[3,4]			
Total expenditure on health per capita	11.9	41.3	96.2
Total public expenditure on health per capita	5.9	16.3	
Share of health in the government budget	10.3	8.7	

[1]Data of MMR, TFR, nutritional and service coverage indicators are for years 2005 and 2010.
[2]Nutrition indicators are for Sub-Saharan African developing countries' average only, while others are for the whole regional average.
[3] 2012 census data.
[4]All health financing indicators listed under "2010" indicate latest year data.
[5]All per capita expenditure data are in the unit of current US$ (i.e. at exchange rate rather than purchasing power parity).
Source: DHS, Census 2012, World Development Indicators and WHO data.

A.2 Technical soundness

The Program's focus on quality of PHC in general and RMNCAH in particular is appropriate

5. A large share of health challenges in Tanzania, including RMNCAH, can be effectively prevented and managed at the PHC level, using a well-known package of evidence-based cost-effective interventions.[24] In Tanzania, access to health care has sharply improved in recent year with more people being within 2 hours of a health facility. Moreover, 3 out of 4 (74.9 percent) facilities offer services for women to give birth which is a critical need in a high fertility environment.

6. However, the challenge is the quality of PHC in general and RMNCAH in particular. For example, the quality of basic and comprehensive obstetric care is low. According to the 2012 Service Availability and Readiness Assessment (SARA), only 32.3 percent of dispensaries and 50 percent of health centers had the capacity to provide BEmNOC services. Among all hospitals, around 73 percent met CEmNOC service standards. As the result, the RMNCAH continuum is weak in Tanzania. More than half of health workers are either absent or late during work hours. According to SDI (2014), although on average 14.3 percent of health providers in surveyed facilities were absent from the facility, absence was more prevalent in Dar es Salaam where only1 out of 5 (20.7 percent) were in fact found in the facility. Moreover, doctors especially those in urban areas are the most likely to be absent and their absence is more likely to not have been approved. There is limited adherence to good clinical practices. A review of clinicians' ability to manage maternal and neonatal complications under the SDI 2014 showed that providers surveyed adhered to only 30.4 percent of the clinical guidelines for managing maternal and newborn complications. There was no significant difference between the performance of public and private (for and not-for-profit) providers. Doctors are again more likely to adhere more closely although they would follow only about 35.7 percent of guidelines. Further, essential drugs are frequently out of stock, and facilities are in poor conditions.

7. Poor quality of PHC results in low utilization despite relatively good access. For instance, studies show that community perceptions of the quality of the local health system influence women's decisions to deliver in a clinic. Improving quality of PHC services and communicating this to communities therefore will assist efforts to increase facility delivery in Tanzania.[25]

Key bottlenecks to quality of PHC and RMNCAH have been clearly identified under the Program

8. Under the overall BRN initiative by the Office of the President, the BRN in Health was developed through an intensive six-week "health lab" process (22 Sep – 31 Oct 2014). It involved 138 representatives from 65 agencies representing key stakeholders in the sector (including academia, government officials, development partners, CSOs, private sector representatives and others). A total of 32,000 person hours was devoted to the development of BRN. The BRN process identified the following bottlenecks to quality of PHC in Tanzania on the supply side.

[24] The World Health Report 2008 "*Primary Health Care: Now More Than Ever*' World Health Organization
[25] Kruk ME, Rockers PC, Mbaruku G, Paczkowski MM, and Galea S. *Community and health system factors associated with facility delivery in rural Tanzania: a multilevel analysis*. Health Policy. 2010 Oct;97(2-3):209-16.

9. First, the limited number of human resource for health (HRH) is a major constraint to PHC service delivery. Nation-wide, there are 554 dispensaries without skilled health workers; of which 135 (25%) are in the 9 regions with critical HRH shortage (HMIS 2014). Instead, they are staffed by medical attendants who are not qualified to manage patients by themselves. The national average ratio of clinicians and nurses per 10,000 population is low at 7.74 (compared to 22.8 as per WHO recommendations). HRH is unevenly distributed across regions, districts and health facilities: 74% of doctors are found in urban settings, resulting in a doctor to population ratio 17 times higher in urban than rural areas. Kilimanjaro, Dar es Salaam and Mwanza have 75% of all skilled HRH (HRH Profile 2014). The current HRH planning process relies on LGAs to identify their HRH needs and then submit them to POPSM for approval. The process often does not take into account the existing distribution of skilled HRH workforce in the country.

10. Second, decentralization in the health sector has not fully materialized, hindering the operations of facilities. Health facilities have limited financial autonomy to utilize their own funds. Most PHC facilities do not even have a bank account. Funding for PHC is channeled to LGAs which unfortunately represent a major bottleneck preventing resources to reach lower levels. Without adequate resources, PHC facilities at the frontline do not have the basic inputs to ensure structural quality of care.

11. Third, there is a poor accountability for results at all levels, including between (i) central government and local government authorities (LGA), (ii) LGA and facilities, (iii) facilities and communities. More than half of health workers are either absent or late during work hours. There is no systematic effort to monitor quality of care, provide accreditation or conduct continuous quality improvement in PHC.

12. Fourth, poor supply chain management leads to frequent stock-outs of essential drugs and medical supplies in PHC facilities. Less than 50% of health facilities have updated stock cards. The working capital of the Medial Store Department (MSD) has been depleted due to the growth of debt. MSD's capacity to deliver medicines is limited to around 65% of health facilities. The remaining 35% needs to be provided by the private sector.

13. Fifth, the RMNCAH continuum is weak. While there are various Development Partners funding community health worker (CHW) interventions in various parts of the country, CHWs have not been formalized as part of the existing health care structure. Outreach services have not been fully established to enable women and their families to receive selected RMNCAH services in their communities. Average readiness score for EmONC was found to be 53% for facilities (SARA 2012). Blood transfusion services are located at urban centers, far away from health facilities that conduct CEmONC services; access to blood is a concern because of this.

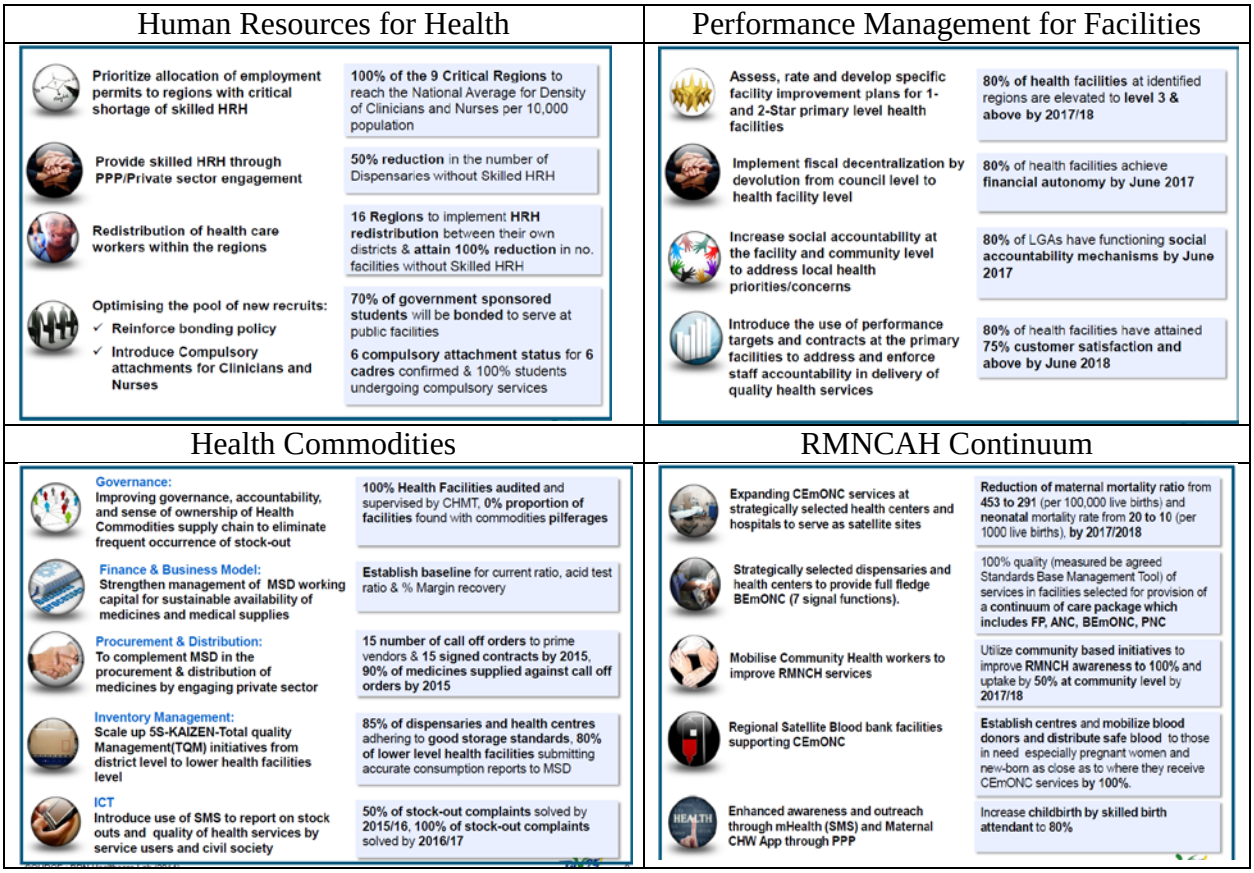
The Program design has clear causal links between the challenges, interventions and expected results

14. On the basis of the identified challenges, under BRN in health, the country has developed interventions which correspond to each bottleneck under Program. Table 20 represents a summary of key BRN interventions for each bottleneck and the results. Figure 5 explains the conceptual framework of BRN in health. RBF is seen as an activity within the BRN work stream "Performance Management" to help incentivize facilities to improve.

Program interventions are technically sound

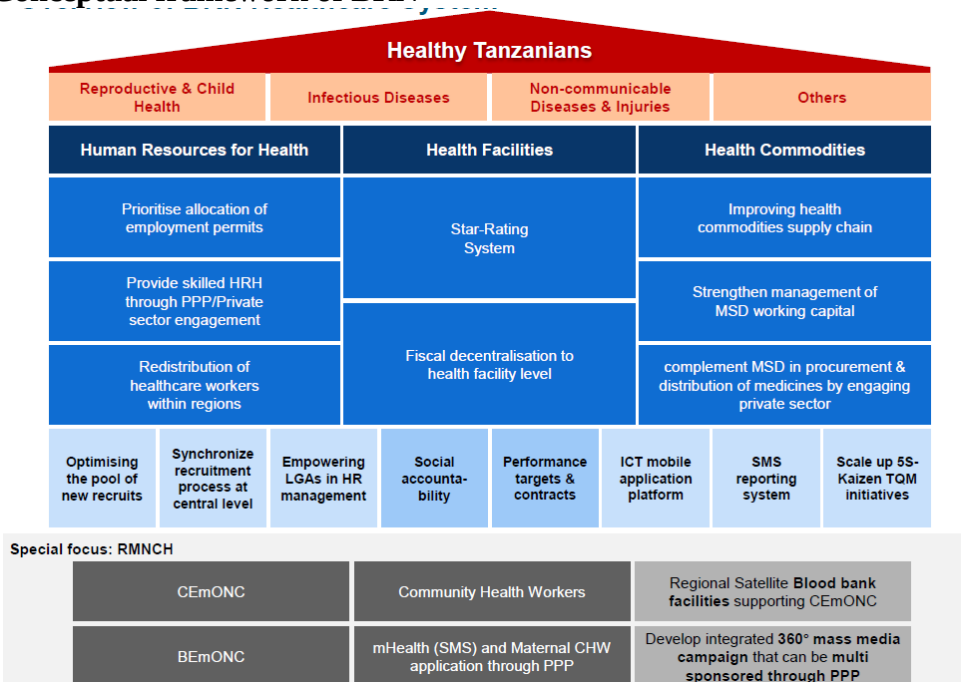
15. The BRN in Health supports evidence-based, cost-effective interventions. Accreditation has been shown to improve quality of care in both OECD and LMIC countries (although the number of evaluations for LMIC is fewer). The same applies to quality improvement plans for health facilities. Fiscal decentralization contributes to provide greater managerial autonomy, which in turns facilitates service delivery. Social accountability is universally accepted as a mechanism to hold providers accountable for results as per the WDR 2004 conceptual framework. HRH represents a critical input for quality of care and, in fact, a dimension of structural quality. For maternal and neonatal care, access to quality BEmONC and CEmONC is essential.

Table 20: Summary of Key BRN Interventions Corresponding to Each PHC Bottleneck



Source: BRN in Health, PDB 2015

Figure 5: Conceptual framework of BRN



Source: BRN in Health, PDB 2015

16. Given the nutrition challenges, the program incorporates nutrition specific and sensitive interventions in the health sector to address under-nutrition including stunting.[26] High impact nutrition specific interventions in the program include (i) growth monitoring/promotion among children under-five, (ii) vitamin A supplementation for children between 6 and 59 months (to support growth and help combat infections among children), (iii) iron and folic acid (IFA) supplementation for pregnant women (to reduce the risk of low birth weight, maternal anemia and iron deficiency); (iv) home visit to provide nutrition/health education by Community Health Workers (CHW) during the first 1,000 days of life (from pregnancy to two years of age). Appropriate incentives are built into the program at the CHW, facilities, LGA and national levels to stimulate performances related to such indicators.

17. The government of the Republic of Tanzania is intending to take urgent measures[27] to improve the civil registration and vital statistics (CRVS) system. The 2012 census revealed that birth registration coverage in Tanzania is at 15% (among the lowest in Africa and in the world) and a similar situation exists for death registration, while cause-of-death documentation[28] is also far from satisfactory. As a first step, a comprehensive assessment[29] of the CRVS was undertaken to identify underlying bottlenecks. A strategic plan[30] has also been drafted by Registration

[26] Nutrition is a multi-sectoral issue. While the health sector certainly has a role, interventions by many other sectors is required, including education, social protection, agriculture, water and sanitation, etc.
[27] In line with the framework of the Commission for Information and Accountability of Women's and Children's Health (COIA) and the ministerial declaration of the second conference of African Ministers Responsible for Civil Registration.
[28] Although this was not assessed by the census.
[29] A draft document is to be released soon.
[30] Not yet publicly shared.

Insolvency and Trusteeship Agency (RITA) – the agency responsible for CRVS- and the National Bureau for Statistics (NBS) with involvement of MOHSW and PMO-RALG and other relevant stakeholders. The strategy intends to mainstream CRVS in Tanzania with a specific focus on the role of the health sector given its close connection with birth and deaths. UNICEF has already been supporting a pilot with registration at the health facility level and is planning to scale this up to 10 new regions (with 2 regions added per year). The Canadian Department of Foreign Affairs Trade and Development (DFATD) is currently the main donor providing assistance to improving CRVS in Tanzania through supporting a variety of agencies such as the NBS[31] and RITA[32] as well as through WHO[33] to support the development and implementation of the abovementioned CRVS assessment and strategy.

18. There is an emerging global body of evidence on the effectiveness of facility-level performance based incentive schemes such as the RBF in improving coverage and quantity of health services. The RBF also benefits from a wealth of practical RBF experiences generated by other projects supported by HRITF in many Sub Saharan African countries. The list of payment indicators in the RBF scheme balances pay-for-quantity vs. pay-for-quality to incentivize the delivery of a set of cost-effective interventions with inputs supported by BRN in health.

19. Under the program, the RBF activity will include incentives for community health workers (CHWs) and traditional birth attendants (TBAs) to escort pregnant women to deliver in the health facility as well as to report any non-institutional maternal and perinatal death within 24 hours to the facility. In line with the upcoming national CRVS strategy, health facilities will register any births and deaths (including cause of deaths) as part of the RBF program, in line with the upcoming national CRVS strategy. Performance indicators for health facilities will be developed to incentivized CRVS-related activities at the facility level.

20. In summary, from the technical point of view, the proposed program has many of the critical building blocks required for delivering results. These include:

- Strong political commitment (including the Office of the President) to PHC and RMNCAH;
- The focus on the key challenges faced by PHC in Tanzania;
- The incorporation of BRN in Health in HSSP IV and inclusion of RBF as a provider payment mechanism in the draft health care financing strategy;
- Technical soundness and alignment with international evidence and best practices; and,
- Clearly defined interventions, which are supported by relevant country and international experiences.

[31] For more information on support for NBS, please see: http://www.acdi-cida.gc.ca/CIDAWEB/cpo.nsf/vLUWebProjEn/EAE2AAC1CA21D095852577110037205 8?OpenDocument and http://www.acdi-cida.gc.ca/CIDAWEB/cpo.nsf/vLUWebProjEn/31233EB567EAC1C585257BAE00359A76?OpenDocument

[32] Support for RITA is through UNICEF for the implementation of the Birth Registrations Strategy

[33] For more information on support for CRVS Country Assessment and Strategy through WHO, please see: http://www.acdi-cida.gc.ca/CIDAWEB/cpo.nsf/vLUWebProjEn/F9B386E2EC337E2285257CE100380967?OpenDocument and http://www.acdi- cida.gc.ca/CIDAWEB/cpo.nsf/vLUWebProjEn/CA0101FA9A04446A85257CE100384693?OpenDocument

B. Expenditure framework

21. In Tanzania, at the national level, documents such as the Tanzania Development Vision (TDV) 2025, MKUKUTA II, FYDPI and currently the BRN initiative outline key policy priorities and targets. At a sectoral level, Health Sector Strategic Plan IV, as well as National Key Results Areas (NKRAs) of the BRN present policy priority objectives and targets to be achieved over a certain period of time. Aligning financial resources through the budgets and actual spending with the policy priorities at all levels is among the critical inputs for effective implementation and achievement of intended results.

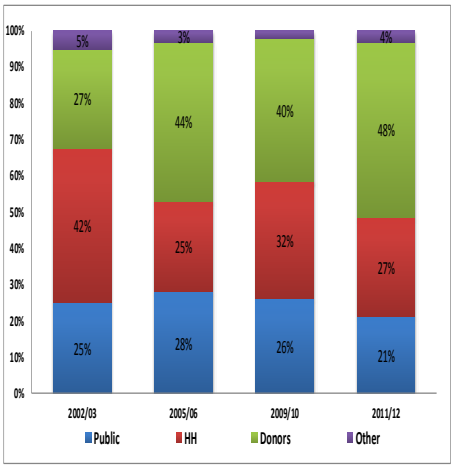
22. Tanzania has a well-established structure of planning and budgeting, both at the central and decentralized levels. In addition, there is an annual Public Expenditure Review (PER) process that helps fiscal policy formulation and management. Under the PER process, a rapid budget analysis (RBA) is conducted each year to assess the consistency of the approved budget and actual public expenditures and the government policy priority objectives. As such, a comprehensive review of the expenditure framework of the government's program on primary health care can be derived from the budget analysis of the BRN in health, national health accounts (NHA) for several years, annual PERs conducted by the MOHSW, RBA for 2014/15 and 2013/14 and reports of the CAG for the sector.

23. The medium term financial prospects of Tanzania appear to be sound with stable GDP growth. The Tanzanian economy is projected to achieve a rate of growth of approximately 7 percent in the medium term. The main drivers of growth, construction, communication and transport sectors are accompanied by an increase in public investment, including through the implementation of the BRN initiative. Domestic demand for communications, financial services, retail trade and construction is expected to remain sustained through technological changes and the rapid urbanization process. The rate of inflation is expected to remain steady at approximately 5 percent. The estimated fiscal deficit for 2014/15 is 3.7 percent with this figure declining to approximately 3 percent in future years. At these levels, the value of public debt will stabilize at the equivalent of 31 percent of GDP.

24. The share of 2014/15 budget allocated to priority sectors defined by MUKUTA II (which includes health) is around two-third of public resources, which is about five percent lower than in 2013/14. This decline is principally explained by the increase in the debt-service payment, which is anticipated to absorb close to 10 percent of total expenditures. The resulting limited fiscal space, due to the rapid growth in the level of public debt in recent years, constraints the Government's commitment to finance fully the programs identified BRN initiative.

25. Health is a priority sector under the Big Results for Now (BRN) program starting 2015/16. However recognizing the constraints in fully financing the BRN initiatives in 2014/15, the BRN in Health preparation process focused largely on reducing inefficiencies and wastage in the sector than raising additional resources. As such, additional resources identified for BRN in Health over the 3 year period was US$100 million, significantly lower than that planned in other BRN areas.

Figure 6: Total Health Expenditure by Financing

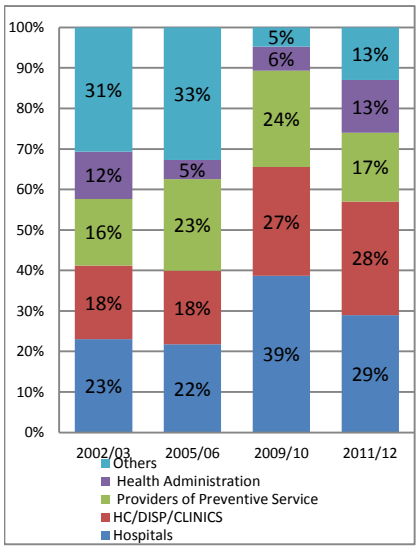


26. Overall, Tanzania spends a significant share of GDP on health (7 percent). However, 48 percent of health spending is from external financing (70 percent of which is off-budget) while household out of pocket spending is 27 percent and declining. Public sector share of total health spending is low at about 21 percent while share of other private spending (private firms) is marginal at 4 percent.

27. The share of health in the budget has been declining over the years and fell to 8.1 percent in 2014/15, down from 9.3 percent in 2013/14, despite increased local funding into the health sector. The per capita health budget in 2014/15 is around Tsh. 31,132, which is equivalent to a 14 percent decline in real terms compared to 2013/14, and only one-third of the target recommended by the WHO (US$54 per capita or TSh 91,800). A reversal in this trend is expected in the near future with local contribution to the sector continuing to increase and inclusion of Health in the Big Results Now (BRN) initiative. Through the support for the BRN initiative, the government is committed to increasing resources for primary health care. The government is also aiming to allocate about 80 percent of the resources under the BRN in Health initiative through PMORALG to LGAs.

28. While public spending in health appears to be allocated efficiently along broad categories, there is still room for improvements in efficiency and reduced wastage. According to the 2011/12 NHA figures (Figure 7), hospitals receive about 29 percent of health funding, primary health care about 28 percent, preventive health about 17 percent while 13 percent is spent on administration.

Figure 7: Total Health Spending by Provider, 2002/03 – 2011/12

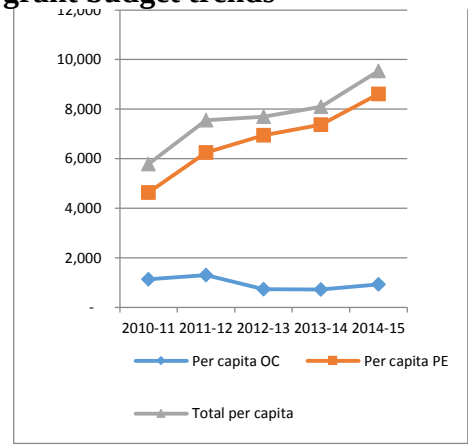


29. Resource flows for PHC are however fragmented through various MDAs, and LGAs are still fairly dependent on the central level for key inputs. In Tanzania, there are three budget line items: personnel emoluments (PE), other charges (OC) and development. All non-salary recurrent spending is within the OC. Fund flows to LGAs from domestic resources are transferred directly from MOFEA as (i) PE block grants and (ii) recurrent health block grants (LGA level OC). The rest are controlled by the central pool and includes: (i) part of OC allocations through external

financing via MOHSW sent to LGAs (HBF) and (ii) medicines allocations which are transferred as goods instead of cash from MSD to LGAs. LGAs are therefore very reliant on the central level for key inputs that affect primary care service delivery. LGAs also receive own-sources revenues through user fees and other contributions such as CHF but given low enrollment in CHF program and high level of exemptions, these are a small share.

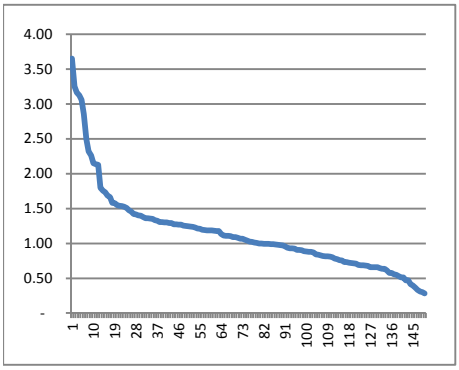
30. While increasingly the amount of resources allocated to LGAs for primary care provision, there is limited flexibility at the health facility level in its use. LGAs are legal entities and are responsible for the delivery of primary health care (district hospitals, health centers, dispensaries, public health, and community health programs). In 2014/15, about 45 percent of the health recurrent budget was allocated to LGAs through MOFEA via block grants. On a per capita basis, the block grant budget has increased from Tsh 8,099 in 2013-14 to Tsh 9,546 in 2014-15 due mainly to growth in the public expenditure budget. The other costs budget has been relatively flat during the same time period (Figure 8). Therefore, LGAs are highly dependent on other sources of financing OC in health, including from central government, from external financing, and from own sources, and from internally generated revenues.

Figure 8: Per capita LGA block grant budget trends



31. Geographic inequality in Health Block Grant (OC and PE) distribution amongst LGAs remains substantial and continues to widen. Equity between LGAs has been traditionally assessed by plotting the ratio of per capita funding an LGA receives over the average across all LGAs. In Figure 5, LGAs plotted on the left receive the highest allocations, while those on the right receive the lowest. Due to incomplete budget or population data for some districts, a total of 152 districts are assessed.

Figure 9: LGA level per capita Health Block Grant Spending FY2014-15, as a multiplier of average per capita spending sorted in descending order



32. Figure 9 speaks strongly to the persistence of highly unequal health block grant (OC and PE) distribution amongst LGAs. Excluding Kibaha which has an unusually high per capita budget of Tsh 52,655, the top five districts - Mwanga, Mafia, Kibaha and Kisarawe, and Siha average about 31,000 Tsh per Capita (3.25 times the national average); while the bottom five –Nzega, Itilima, Kyerva, Uvinza, and Bariadi average about 3035 Tsh per capita (0.32 times the national average). On a population basis, those in the privileged top 10 percent of the population get twice the national average; while the least privileged 10 percent get 40 percent of the national average. While comparison with previous year's RBA is analysis is far from perfect given the incorporation of new districts and new population figures, increasing standard deviation in per capita health block grant spending at the LGA level (from 0.65 in 2013-14 to 0.68 in 2014-15) suggests that inequality in resource distribution might be widening amongst

LGAs. For 2014-15, the variation is significantly lower in the OC than in PE (standard deviation of 0.60 and 0.72 respectively).

33. Given the huge variation in OC among LGAs, this program advocates for the government to adopt a formula that favors underserviced areas using a combination of population, poverty and health outputs similar to that of the HBF. Currently. MOFEA uses a population based formula to allocate OC to LGAs. The health basket fund (HBF) uses an equity based formula for the allocation of HBF resources to LGAs. The HBF criteria include: population (70 percent of weight), poverty (10 percent), health outputs (10 percent) and geographical constraints (10 percent).

34. Further, personnel distribution and retention has been a challenge in the country, especially for lower level health facilities, and for rural areas, resulting in lack of availability of qualified personnel at facilities. Through the BRN initiative, special attention is being provided for a more equitable distribution of skilled personnel from the public sector, especially for dispensaries and health centers. Additionally, through the public-private partnership, service level agreements are being signed with nongovernment organizations to provide quality PHC services in rural and underserved areas. Other measures planned include, settlement allowances for staff retention, incentives through the results-based financing mechanism to motivate staff for better performance at dispensary and health centers. Emphasis is also on preventive and early care (incentives in RBF to support ANC visit within the first 12 weeks). Community workers are also being incentivized to create the appropriate and timely referrals to health facilities.

35. New directives under the BRN in Health suggest greater fiscal decentralization to health facilities. While PE is directly allocated to staff bank accounts by MOFEA, decentralized OC budgets are allocated to the providers (health facilities) through the LGAs. LGAs however use their own discretion in allocating OC to health facilities and funds are not always for direct facility use. This hinder innovative solutions to solve local problems and ability of facilities to implement facility improvement plans. BRN in Health aims to strengthen fiscal decentralization through empowering facilities to plan and manage funds. LGAs would be required to transfer part of the resources (OC, HBF, council own source funds) directly to health facility bank accounts for facility level use.

36. Budget execution rate in the health sector in 2013/14 performed relatively well compared to other sectors, even though arrears have grown substantially. Overall, the health sector budget execution rate in 2013/14 declined to around 86 percent, down from 89 percent in 2012/13. However, the recurrent budget performed far better than the development budget, at 91 percent compared to 80 percent. With regards to the development budget, both foreign and local budget were under executed in 2013/14. Nevertheless, the execution of the locally funded component of the health budget was lower than the foreign funded component. Moreover, there is a buildup of arrears with Medical Stores Department (MSD), estimated to be around US$50-60 million by the end of 2013/14. Recognizing this, the Health Commodities work stream of the BRN focuses on improving governance, accountability, and sense of ownership of health commodities supply chain while strengthening management of MSD working capital for sustainable availability of medicines and medical supplies**.**

C. Program's results framework and monitoring

37. The DLIs have been chosen to address the bottlenecks along the results chain that require incentivizing, with both ambition ("stretch") and feasibility ("realism") taken into account. All PDO and the intermediate results indicators were selected as DLI because of their ability to measure and incentivize key intended changes in the health sector.

38. A set of specific, measurable and relevant indicators was agreed with the GOT to monitor the program. As part of the M&E harmonization agenda under SWAP, the vast majority of Program indicators are extracted from the Government's M&E framework (e.g. HSSP IV and BRN in Health indicators). This aims to increase the Government's ownership in Program results and reduce fragmentations in M&E. As discussed in the M&E section above, Program results will be monitored through the routine health management information system or administrative data systems of MOHSW and PMO-RALG. This is a deliberate choice to (i) align Program's monitoring methodology with that of the government; (ii) reduce the country's reliance on surveys to generate data; (iii) maximize the use of routine information platforms; and (iv) help further strengthen the country's information systems.

39. The cornerstone of PHC information system is the District Health Information System 2 (DHIS 2). Tanzania completed its country wide rollout of DHIS 2 in 2013 after deploying a revised health management information system tool national wide. Data from all PHC facilities in the country are now entered monthly in the National Data Warehouse through internet connections.

40. As part of monitoring progress towards the PDO, the Bank team will conduct regular implementation support missions based on the detailed implementation support plan (Annex 9), whose focus would be on timely implementation of the agreed program action plan (Annex 8), provision of necessary technical support, conduct of fiduciary reviews, and monitoring adherence to verification protocols, where appropriate.

D. Governance structure and institutional arrangements

41. An adequate governance structure and coordination arrangements are in place to implement the program. Coordination mechanisms for the MOHSW and PMORALG to collaborate with each other as well as to coordinate with country stakeholders and external development partners are well established. A Steering Committee will be established between the key implementing agencies that will meet biannually.

42. In addition, as part of BRN, there are various mechanisms put in place by the GoT to ensure the program's success results by holding various actors accountable for results *at all levels* along the hierarchy, from front-line providers to the office of the President. First, in BRN, there will be governance and delivery structures at different levels (e.g. Ministerial Delivery Unit, NKRA Steering Committee). Second, the proposed restructuring of the HBF will help foster the accountability of LGAs as discussed above. Third, RBF will introduce performance-based contracts with PHC facilities to hold them accountable for service delivery. Fourth, various social accountability mechanisms will be used in both BRN and RBF (e.g. Health Facility Committees, use of CSO for verification of results). Last but not least, very high level of country ownership in these two initiatives is a major enabling factor for future program results.

E. Economic analysis of the Program

43. The Program supports strengthening of the primary health care delivery system particularly maternal and neonatal child health services nationwide. Primary Health Care in Tanzania is provided at the community level (households and communities) and in health facilities (dispensaries, health centres and the district hospital). While a range of services are provided at the PHC level, services targeted towards women of reproductive age and children constitute the largest share. These include integrated management of childhood illnesses (IMCI), malaria, tuberculosis, HIV prevention and control, sexually transmitted infections (STIs), reproductive maternal and child health (RMCH) and prevention of mother to child transmission (PMTCT). Over the period 2009 to 2014, the number of health facilities and the number of health workers deployed have increased, but per capita utilisation of health services did not increase significantly primarily due to low perceived quality of care.

44. Quality improvement of primary health care is therefore a major focus of HSSP IV, propelled by the BRN in Health activities. The development of a certification and accreditation system for facilities will underscore this. Quality is also expected to improve through adequate supply of medicines and health products. Performance management systems (including provision of incentives for improved PHC quality especially at the local government and facility level) will further enhance quality as well as accountability of health workers.

45. This economic analysis covers (i) the rationale for public investment, (ii) the summary of costs and benefits and (iii) risk-sensitivity analysis.

46. ***Rationale for public investment.*** Government intervention in the health sector at the primary care level is strongly justified in Tanzania on the ground of improving equity, as well as positive externalities and public goods. The poor are highly dependent on the public sector for services, especially in the rural areas where choices are limited. However, quality of care in PHC facilities is low. Public subsidy is thus called for to improve quality of PHC care where there is poor access to services. Improved quality of care also means improved technical efficiency which should help reduce overall costs in the medium to long-term. The BRN in Health and the program, with an emphasis on increased resources to primary care encourages domestic funding to focus on areas where there is a clear role for government. Further under the health facility based incentives, facilities are incentivized for providing services to the extreme poor as identified by the conditional cash transfer (CCT under PSSN) program thus directly targeting those most in need. Additionally, as geographic inequality in health block grant distribution amongst LGAs remains substantial and continues to widen, the program emphasizes the allocation of resources in a more equitable manner including the promoting the use an equity formula for distribution of resources to LGAs.

47. The program supports strengthening fiscal decentralization to the level of the health facilities to foster innovation and cost-effective local solutions**.** Decentralization of service delivery in Tanzania is still incomplete with local governments still reliant on central levels for key inputs (medicines, part of operating cost funding etc.). The introduction of bank accounts at the facility level with clear financial management guidelines supported and incentivized by the program brings resources closer to where services are delivered and helps foster local solutions to shortages in health personnel and medicines.

Summary of Benefits and Costs

48. There is considerable amount of literature that points to the efficacy of primary care services. Primary care services is associated with improved control of routine illnesses that have serious consequences if left untreated. Availability of such services close to where the population reside improves patient satisfaction. Longitudinal care offered by primary care services reduces use of ancillary and laboratory services, leads to shorter lengths of stay at hospitals and improves patient compliance.

49. While primary care services are largely associated with reducing burden of disease and at a low cost, there are welfare benefits that accrue to a household as a result of prevention of severe disease. Severe disease can limit the ability of patients and care givers to work and lead to consumption of household assets in purchasing of care. Through prevention and early treatment, accessible primary care services can thus reduce consequences of ill-health for households, reduce absenteeism, and enhance children's performance at school.

50. This section compares the costs of the program with the measurable benefits that arise from the implementation of the program. Economic benefits of the program are analyzed in terms of infant and maternal deaths averted as well as reduced productivity loss and illness cost loss. It should be noted that this is an underestimate of the actual economic impact of the program. Other benefits not quantified here include: poverty alleviation, psychological benefits of a healthy population, etc.

51. The economic analysis simulates the number of infant and maternal deaths that would be averted as a result of the program over the

Table 21: Tanzania, Demographic and Health Indicators (2004-5 and 2010)

	2004-5	2010
Total Population, millions	33,710,000	43,190,000
Women of reproductive age - Share of pop. - Number	 23 7,753,300	 24 10,365,600
Maternal mortality ratio (MMR)	578	454
No. of maternal deaths	8,261	7,620
Crude Birth Rate (CBR)	42.4	38.86
Infant mortality rate (IMR)	68	51
Neonatal mortality rate (NNMR)	32	26
No. of infant deaths	97,193	85,597
No. of neonatal deaths	45,738	43,637
No. of new births	1,429,304	1,678,363
% of births delivered by professionals	46.3	50.6
% of births delivered at facilities	47.1	50.2
No of births by professionals	661,768	849,252
No of births at facilities	673,202	842,538

Source: Demographic and Health Survey, 2004-5 and 2010

period 2015-2035. It also assumes that use of services will improve primarily due to improvements in quality of care (less drug stock outs, access to qualified health personnel) and with the presence of more motivated staff that perform better as a result of the results-based financing and other interventions supported by the program.

52. The baseline information on morbidity profiles and use of services used in the analysis is from the Demographic Health Surveys (2005, 2010) (Table 21). The baseline for the causes of infant deaths in Tanzania is from the WHO database (2010) (Table 22).

Table 22: Causes of Death for Infants, 2010

Causes of Death	Percentage of infant deaths	
	2005 (%)	2010 (%)
Neonatal period	**47%**	**50%**
Neonatal tetanus	3%	
Severe infection	29%	19%
Birth asphyxia	27%	29%
Diarrhea, dehydration	3%	1%
Congenital malformation	7%	7%
preterm births	23%	35%
Others	8%	9%
Post-neonatal period	**53%**	**50%**
HIV/AIDS	12%	9%
Diarrhea, dehydration	23%	13%
Measles	1%	1%
Malaria	31%	17%
Pneumonia	29%	20%
Injuries	3%	8%
Others		32%

Source: WHO, 2006, 2012.

53. Approximately half of infant deaths are among children in the neonatal age group (first month of life). Among neonates, sepsis and respiratory distress are the leading causes of death and adequate care at birth or immediately after birth can significantly reduce mortality. Among post-neonates, malaria, pneumonia, and dehydration due to diarrhea are the leading causes of death.

Assumptions

54. The analysis assumes that the program will avert infant and maternal deaths as institutional deliveries as well as quality of antenatal care increases. Additionally, reduction in morbidity and increased use of appropriate health services further reduces mortality among infants. The analysis is run for three different sub-groups: (a) neonates, (b) post-neonates, and (c) pregnant women. (Table 23)

55. Between 2005 and 2010, the annual increase in institutional deliveries was 1%. To calculate neonatal deaths averted, the model assumes that with improved quality of care, institutional deliveries will increase by about 5% per year during the program period (2015-2020). Following which, as a result of improved quality of care, institutional delivery will increase by 2% per annum. The model starts with 52% institutional delivery in 2015 and reaches 88% institutional delivery by 2034.

56. Further it is assumed that the risk of a neonatal death varies by place of delivery. For instance, in 2014, based on trend data using the Demographic Health Survey, the risk of a neonatal death at a health facility is 0.003. In comparison, the risk of a neonatal death at home is 0.04. As the quality of health services improves, the risk of a neonatal death at a health facility reduces (from 0.003 in 2015 to 0.001 in 2020). In addition, services quality improvements will further result in an increase in the share of institutional delivery thus having an exponential effect on the

number of neonatal deaths averted. Further as quality of antenatal care improves, the risk of a neonatal death further reduces.

57. For post-neonates, the intervention focuses on improved coverage and quality of care for malaria, pneumonia, diarrhea/dehydration and HIV.

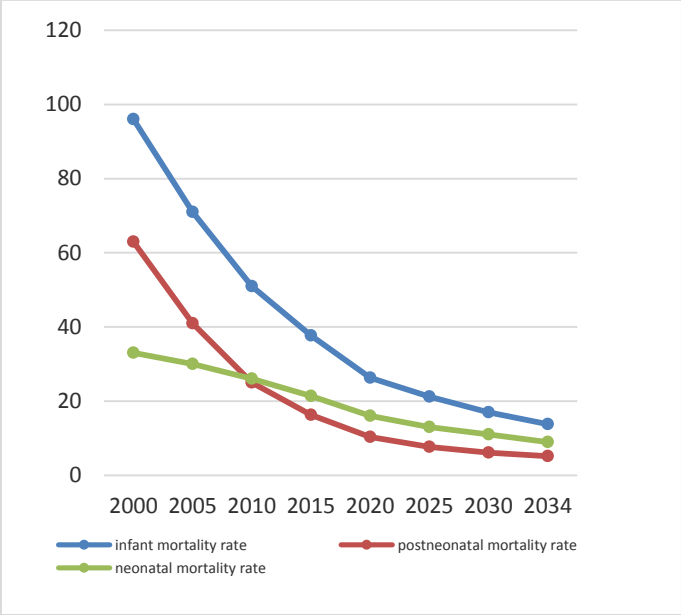
58. A similar simulation was conducted to estimate the number of maternal deaths averted as a result of the program. Here, it is assumed that maternal deaths would be averted as more and more women receive quality antenatal care, deliver at health facilities or are assisted by skilled attendants and receive quality postnatal care within 48 hours of delivery. Maternal morbidity would also reduce as women seek treatment and comply with the treatment protocols (e.g. iron supplementation for anemia). Subsequently, less women would need additional care, resulting in savings in the cost of treatment and travel. Women's productivity too would improve as their health status improves.

59. In 2014, based on trends from DHS data, the risk of a maternal death when delivering at a health facility is at 0.001 and when delivering at home is at 0.007 respectively. It is further assumed, that as a consequence of improved quality of health care, the risk of a maternal death at health facility and when the delivery is attended by a skilled attendant reduces during the program intervention period.

Table 23: Assumptions Used for the Simulations

Intervention Assumptions	2010-2012 baseline	2015	2016	2017	2018	2019	2020	2034	Remarks		
									2005-2010	2015-2020	2021-2035
Neonates											
% birth delivered at health facilities	51%	52%	55%	57%	60%	63%	66%	88%	annual increase by 1%	annual increase by 5%	annual increase by 2%
% births delivered at home	49%	48%	45%	43%	40%	37%	34%	12%			
Risk of dying if delivered by skilled birth attendant	0.003	0.003	0.002	0.002	0.002	0.002	0.002	0.002	risk of dying went from 0.014 to 0.008	reduced risk of dying due to improved quality of care	no change in risk after intervention period
Risk of dying if delivered at home	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04			
Share of causes of death for post-neonates:											
Measles	1%	1%	1%	1%	1%	1%	1%	1%		no change in share	
Pneumonia	20%	20%	18%	16%	13%	11%	10%	2%	5% reduction pre intervention period	50% reduction during intervention period	10% reduction post intervention period
Malaria	17%	17%	15%	13%	11%	9%	8%	2%	5% reduction pre intervention period	50% reduction during intervention period	10% reduction post intervention period
Diarrhea	13%	13%	11%	10%	9%	8%	7%	2%	5% reduction pre intervention period	50% reduction during intervention period	10% reduction post intervention period
HIV	9%	9%	8%	8%	7%	7%	6%	1%	5% reduction pre intervention period	50% reduction during intervention period	10% reduction post intervention period
Other causes										5% reductions during intervention period	2% reduction post intervention period
Maternal health											
Risk of dying if delivered at health facilities	0.001	0.001	0.0009	0.0008	0.0007	0.0006	0.0005	0.0005	risk of dying went from 0.0011 to 0.0003	reduced risk of dying due to improved quality of care	no change in risk after intervention period
Risk of dying if delivered at home	0.0073	0.0073	0.0073	0.0073	0.0073	0.0073	0.0073	0.0073			

Figure 10: Infant Mortality Rate Projection, 2000 to 2034



Source: Bank staff calculations. Note: actuals are for 2000-2010. Projections are for 2015 to 2034.

60. The simulation shows several benefits. As shown in Figure 10, infant mortality rate reduces over time from 37 per 1,000 live births in 2015 to 14 infant deaths per 1,000 live births by 2034.

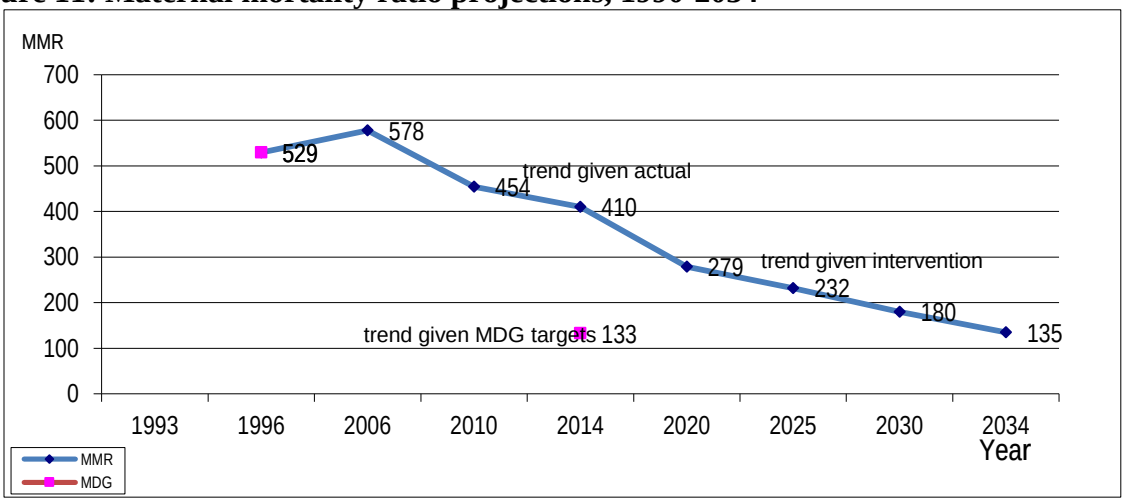
61. Table 24 provides the results of the simulation model of the number of infant and neonatal deaths averted during the program period. Here we assume that 40% of the program cost is allocated for improvements in child health. It is also estimated that the cost of year of life gained (YLG) is US$6, and the cost per disability adjusted life years (DALY) is US$10 during the program intervention period.

62. Maternal mortality ratio too reduces over time from 410 maternal deaths per 100,000 live births in 2015 to 135 maternal deaths per 100,000 live births by 2034 (Figure 11).

Table 24: Results of the economic analysis for averted infant and neonatal death (2015-2020)

Year		Intervention	Averted infant deaths		Number of Infant lives Saved	Years of life gained (NPV)	YLG sum (NPV)	DALY (NPV)	DALY sum (NPV)
		childbirth attended	Neonatal	Post-neonatal					
2014	baseline	51%	total	total	project	project	project	project	project
2015		52%	1034	0	1034	60,063		33,570	
2016		55%	4164	15997	21196	1,231,368		688,230	
2017		57%	6482	18539	46217	2,684,971		1,500,671	
2018		60%	9044	21209	76470	4,442,518		2,482,990	
2019		63%	11868	23648	111985	6,505,804	12,245,807	3,636,192	6,844,366
2020		66%	14149	24404	150538	8,745,547	18,771,869	4,888,018	10,491,880

Figure 11: Maternal mortality ratio projections, 1990-2034



Source: Bank staff calculations. Note: Actuals are for 1990 to 2014. Projections are for 2020 to 2034.

63. Table 25 presents the costs and the measurable economic benefits that arise from the implementation of the program. It shows savings incurred due to death or morbidity averted. In 2011/12, the per capita health spending in Tanzania was US$45 (NHA). Assuming 3% inflation, per capita health spending in future years is calculated. For women's health, it is assumed that US$100 is saved in health spending due to each case of mortality and morbidity averted. Further, reductions in ill-health would reduce absenteeism and this result in productivity gains as earning potential increases. GDP per capita is used as a proxy for earnings potential, while inflation is assumed to be 3% per year. A five percent discount rate is assumed while estimating future costs and benefits.

64. By 2034, it is expected that as many as 1 million infant and neonatal deaths are averted, as are 84,000 maternal deaths. While the analysis focuses on infant and maternal deaths, many of these interventions would also reduce infant and maternal distress and morbidity. Consequently, total health benefits, as measured by a composite measure such as disability-adjusted life years would be significantly greater.

65. The program reaches a positive net present value (NPV) by 2029 (or in its 14th year after program effectiveness). The net benefits accruing to the country are maximized thereafter. We find that the internal rate of return (IRR) is positive but reaches the discount rate level by 2030 (or at 15 years from program effectiveness) making the program an acceptable investment.

Table 25: Net Present Value and Internal Rate of Return (2015-2035)

Averted for child		Averted for mother											
Productivity Loss, $	Illness Cost, $	Productivity Loss. $	Illness Cost, $	Total Benefits $	Discount rate r=5%	Discounted Benefits	Program incremental cost (MNCH) $	Program Net Benefits $	Discount Rate 5%	Discounted Net Benefits	NPV $	IRR $	Year
				0	1			-	1	-			2014
	46,524	121,767	3,971	172,262	1.05	164,059	49,000,000	(48,827,738)	1.05	(46,502,608)	(46,502,608)		2015
	1,011,892	448,989	14,642	1,475,523	1.10	1,338,343	48,000,000	(46,524,477)	1.10	(42,199,072)	(88,701,680)		2016
	2,272,601	836,429	27,276	3,136,307	1.16	2,709,260	64,000,000	(60,863,693)	1.16	(52,576,346)	(141,278,026)		2017
	3,873,023	1,292,436	42,147	5,207,606	1.22	4,284,310	39,000,000	(33,792,394)	1.22	(27,801,086)	(169,079,112)		2018
	5,841,967	1,826,442	59,561	7,727,970	1.28	6,055,067	60,000,000	(52,272,030)	1.28	(40,956,503)	(210,035,615)		2019
	8,088,767	2,314,036	75,462	10,478,265	1.34	7,819,043		10,478,265	1.34	7,819,043	(202,216,572)		2020
	10,650,865	2,618,105	85,378	13,354,348	1.41	9,490,686		13,354,348	1.41	9,490,686	(192,725,886)		2021
	13,553,919	2,952,940	96,297	16,603,157	1.48	11,237,670		16,603,157	1.48	11,237,670	(181,488,216)		2022
	16,825,778	3,321,325	108,310	20,255,413	1.55	13,056,820		20,255,413	1.55	13,056,820	(168,431,396)		2023
	20,496,807	3,726,452	121,522	24,344,781	1.63	14,945,584		24,344,781	1.63	14,945,584	(153,485,812)		2024
933,092	24,442,891	3,983,808	129,914	29,489,706	1.71	17,242,020		29,489,706	1.71	17,242,020	(136,243,792)	(0)	2025
19,703,415	28,836,706	4,450,781	145,143	53,136,044	1.80	29,588,138		53,136,044	1.80	29,588,138	(106,655,654)	-10%	2026
44,251,758	33,715,199	4,963,085	161,849	83,091,892	1.89	44,065,404		83,091,892	1.89	44,065,404	(62,590,250)	-4%	2027
75,414,947	39,118,429	5,524,779	180,166	120,238,322	1.98	60,728,523		120,238,322	1.98	60,728,523	(1,861,727)	0%	2028
113,753,926	45,244,739	6,140,035	200,230	165,338,931	2.08	79,530,853		165,338,931	2.08	79,530,853	77,669,126	3%	2029
157,503,300	51,634,738	6,552,356	213,676	215,904,070	2.18	98,908,142		215,904,070	2.18	98,908,142	176,577,268	6%	2030
207,392,104	58,666,143	7,260,737	236,777	273,555,761	2.29	119,351,472		273,555,761	2.29	119,351,472	295,928,740	8%	2031
263,919,947	66,391,327	8,034,860	262,022	338,608,156	2.41	140,698,683		338,608,156	2.41	140,698,683	436,627,423	10%	2032
327,629,116	74,866,698	8,880,106	289,586	411,665,506	2.53	162,910,020		411,665,506	2.53	162,910,020	599,537,443	11%	2033
399,110,853	84,153,058	9,802,351	319,661	493,385,922	2.65	185,951,965		493,385,922	2.65	185,951,965	785,489,408	12%	2034
475,948,441	93,991,121	10,348,334	337,466	580,625,362	2.79	208,411,040		580,625,362	2.79	208,411,040	993,900,448	13%	2035

Risk-sensitivity analysis

66. The above simulation has taken three scenarios: (a) scenario 1 - status quo, (b) scenario 2 - reduced mortality rates as a result of increased institutional delivery by an annual increment of 5% reaching 66% institutional delivery by 2020, and (c) scenario 3 - reduced mortality rates as a result of increased institutional delivery by an increment of 10% reaching 80% institutional delivery by 2020. The sections above show the results of scenario 2 as compared to scenario 1. When the model is re-run for scenario 3, we find a positive NPV by 2028 (13th year), and IRR is positive and reaches the discount rate by 2029 (14th year).

67. A sensitivity analysis was conducted using variable discount rates of 5% and 12%, and variable institutional deliveries by 2020 of 66% and 80%. The results are shown in Table 26.

Table 26: Sensitivity Analysis

Net Present Value, $	Institutional delivery by 2020	
Discount rate of 5%	66%	80%
Positive NPV	77,669,126	43,395,116
(year)	2029	2028
Positive NPV and IRR above discount rate of 5%	176,577,268	136,913,336
(year)	2030	2029
Discount rate of 12%		
Positive NPV	29,084,054	24,679,887
(year)	2031	2030
Positive NPV and IRR above discount rate of 12%	--	---
(year)	beyond 2035	beyond 2035

Technical risks

68. The program designed by the GOT is technically sound and the risk of non-implementation of program activities is low given the fact that detailed implementation plans with time-bound actions, good division of labor, clear accountability and M&E mechanisms have been developed for all work streams under BRN in Health. Some of the BRN in Health activities are already under implementation such as the "Star Rating" initiative. Although the limited capacity of program implementers remains a concern, the program's annual capacity building plans are expected to help address this issue.

69. In summary, any residual risks related to technical design, implementation and M&E will be mitigated through the use of DLIs, Program's annual capacity building as well as TA to be financed through parallel financing from development partners. These are summarized in Table 27.

Table 27: Technical Assessment: Key Risks and Mitigation Strategies

Risks	Mitigation
Technical Design	
Insufficient financing for the program	- TA for HSSP IV costing and budgetary framework - TA for development of Health Financing Strategy - DLI 1 minimum condition on share of health in GOT's recurrent expenditures
New approaches (e.g. "Star Rating" accreditation, RBF) being implemented on a significant scale in Tanzania for the first time	- Careful pilots with assessments to improve the design - Impact evaluation of selected activities (e.g. RBF) to generate the evidence base for policy making - GOT's own mechanisms for adaptive implementation such as periodic BRN in Health check-ins; mid-term review of the HBF for fine-tuning as needed
High intensity of RBF activity	- Gradual roll-out
Program's imbalance between focus on processes and actual results	- Thorough analysis and stakeholder consultations to strike a balance between (i) key service delivery results and (ii) key bottlenecks in processes which need to be tackled to deliver such key service delivery results
Risk of non-implementation of certain Program activities	
Non-implementation due to poor planning	- Detailed implementation plans developed, with specific time-bound actions - DLI 1 minimum condition to improve planning at the council level
Non-implementation due to lack of accountability	- Accountability mechanisms for each level of implementers - Higher levels are also held accountable for results at the lower levels - DLIs to stimulate performance at every single level: national, regional, LGAs and PHC facilities
Non-implementation due to lack of capacity	- Detailed annual capacity building plans under the Program for all level - DLI criterion related to the development and implementation of such plans - TA provided by development partners though parallel financing
Risks related to M&E	
HMIS does not produce quality data on a timely manner	- TA for DHIS-2 - GOT's plan on Data Quality Audit (DQA) by RHMTs for LGAs under the Program - DLI criterion related to (i) quality of HMIS data (ii) DQA
Lack of information on denominators in routine health statistics	- CRVS initiative - Incentives for CHW and PHC facilities under RBF to fulfill their respective roles in CRVS

Annex 5: Summary Fiduciary Systems Assessment

1. A fiduciary systems assessment (FSA), which involves the assessment of governance and anti-corruption mechanisms, procurement and financial management systems was carried out at the M)HSW, PMORALG, MSD, a sample of 8 regional administrations, 22 local government authorities (LGAs) and 38 health facilities in line with Operational Policy/Bank Procedure (OP/BP) 9.00, Program-for-Results Financing. Teams visited these sampled areas to collect this data. The assessment takes into consideration the BRN healthcare NKRA Lab report; Controller and Auditor General's Report for LGAs and Central Government for FY13; Tanzania PEFA reports for 2006, 2010 and 2013; Annual Performance Evaluation Report of the Public Procurement Regulatory Authority (PPRA); the Procurement and Value for Money Audit reports of selected LGAs and specific assessments done on MOHSW, PMORALG and MSD.

2. The FSA covers institutional and implementation arrangements, fiduciary management capacity and implementation performance. The legal and regulatory framework for this Program's fiduciary systems was found to be comprehensive and in line with international principles and standards for public procurement and financial management. At the facility level, PHC facilities are not currently managing any financial and procurement activities. In that regard fiduciary systems' analysis was carried out at the LGAs and MDAs. The assessment also considered how existing systems handle the risks of fraud and corruption.

A. Institutional Framework and Implementation Arrangements

Legal Framework for Public Financial Management

3. The 1977 Constitution of the United Republic of Tanzania underpins the legal framework for Public Financial Management (PFM), and there are various laws that relate to PFM. The table below provides PFM-related laws that will be applicable to the program.

Table 28: PFM related legislation in Tanzania

Area	Description
Budget preparation, execution, reporting & accounting.	• Public Finance Act 2001, amended 2004 & 2010. • Public Procurement Act, 2011 • Budget Act 2015
Decentralization	Local Government Finance Act 1982.
External Audit	Public Audit Act 2011
Legislative Oversight	The Constitution and the Standing Orders of the National Assembly.

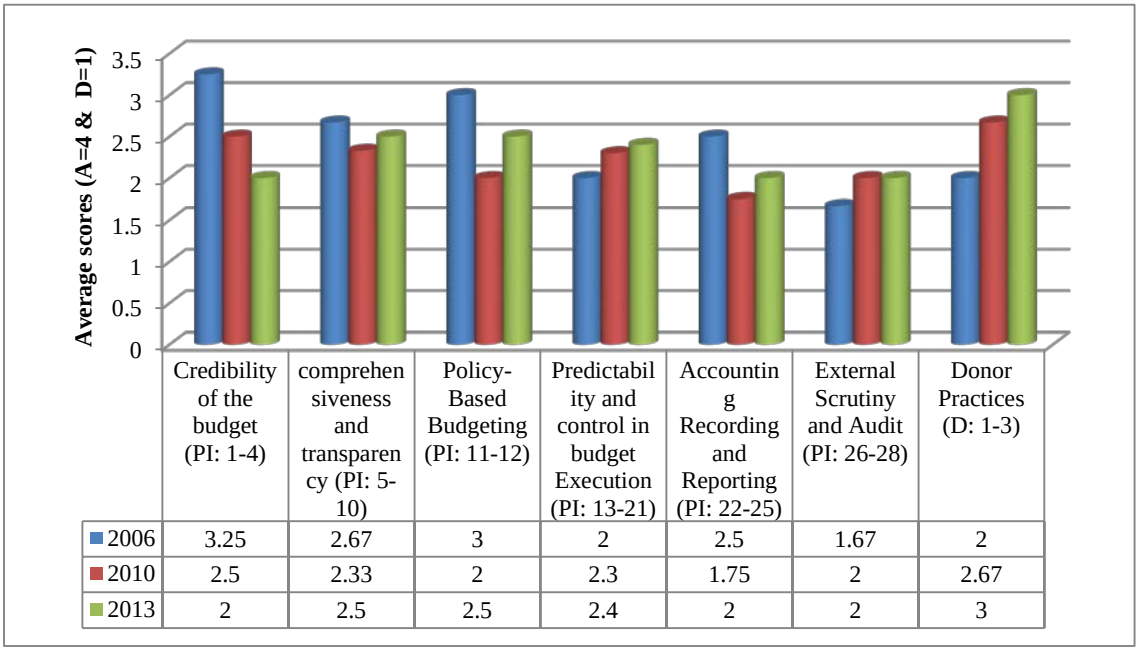
Source: Government of Tanzania 2013 PEFA Report.

Financial Management

4. The Government of Tanzania has undertaken a number of Public Financial Management (PFM) reforms and is now in its fourth PFM Reform Program which commenced on July 1, 2012.

However, the Public Expenditure and Financial Accountability (PEFA)[34] Performance Indicators for Tanzania for 2006, 2010, and 2013 show mixed results as shown in Figure 12 below.

Figure 12: Tanzania Average PEFA Scores for 2006, 2010, and 2013



	Credibility of the budget (PI: 1-4)	comprehensiveness and transparency (PI: 5-10)	Policy-Based Budgeting (PI: 11-12)	Predictability and control in budget Execution (PI: 13-21)	Accounting Recording and Reporting (PI: 22-25)	External Scrutiny and Audit (PI: 26-28)	Donor Practices (D: 1-3)
2006	3.25	2.67	3	2	2.5	1.67	2
2010	2.5	2.33	2	2.3	1.75	2	2.67
2013	2	2.5	2.5	2.4	2	2	3

5. These findings show improvements in predictability and control in budget execution since 2006 although much more remains to be done in relation to the effectiveness of internal controls for non-salary expenditures (PI[35] 20). There are also improvements since 2010 in policy based budgeting and accounting, recording and reporting although the timeliness and regularity of accounts reconciliations (PI 22) needs to improve. External scrutiny and audit has not improved since 2010. There are concerns about the credibility of the budget whose performance has been declining since 2006 mainly because of the composition of expenditure out-turn compared to original approved budget (PI 2) arising out of cash rationing due to resource uncertainty, commitment controls being bypassed and insufficient access to excess liquidity in GoT bank accounts held in commercial banks. As a result expenditure arrears have accumulated and they are paid out of budgets in the following years at the expense of planned service delivery.

6. The Legal and Regulatory Framework for this program's procurement will be governed by the new Public Procurement Act of 2011 (PPA 2011) and attendant Regulations 2013. Procurements at the Ministry of Health and Social Welfare (MoHSW), the Prime Minister Office Regional Administration and Local Governments (PMO-RALG), Medical Stores Department (MSD) and Local Government Authorities (LGAs) will follow the Public Procurement Act No.7 of 2011 and the associated Regulations of December 2013 as well as Regulations for Local

[34] PEFA is a global partnership of bilateral and multilateral donors including the World Bank formed to assess the condition of countries' public expenditure, procurement, and financial accountability systems and to develop a Practical sequence of reform and capacity-building actions (http://www.pefa.org/).
[35] PI stands for Performance Indicator.

Government Authorities (Establishment and Proceeding of Tender Boards) of 2007. Under the PPA 2011, the procurement functions remain decentralized to procuring entities while the Public Procurement Regulatory Authority (PPRA) continues to provide oversight functions. The PPA 2011 has strengthened some of the mandate of PPRA including the power to cancel procurement proceedings after conducting an investigation and being reasonably satisfied that there is a breach of the Act and its Regulations.

7. The PPA 2011 has enhanced the definition of fraud and corruption in broader terms by including definitions of coercive practices, collusive practices and obstruction that was missing in the PPA 2004. Furthermore, the PPA 2011 vests powers in the PPRA to blacklist and debar a bidder who has been debarred by international organizations, such as the World Bank, in cases related or unrelated to fraud and corruption for such period as is debarred by the international organization plus a further period of 10 years (for fraud and corruption cases) or five years (for non-fraud and corruption cases).

8. For the implementation of the Act, a set of regulations have been issued; the Public Procurement Regulations, 2013; Government Notice No. 446 of December 20, 2013. These are supplemented by the local government authorities' (Establishment and Proceeding of the Tender Boards) Government Notice No.177 of 2007 for procurements under the local government authorities. In line with the issued regulations, various documents have been revised as working tools to be in line with PPA 2011; including standard bidding documents (Procurement of Works, Procurement of Goods and Procurement of Non-consulting Services), Standard Request for Proposals, Guidelines on the Tenders Evaluation (Works, Goods and Non-consulting Services), Guidelines on the Technical & Financial Proposals Evaluation and Report Preparation, Guidelines for Preparing Responsive Proposal, Guidelines for Preparing Responsive Bids and Procedural Forms. All these documents are accessible on the PPRA's website free of charge.

9. **Procurement of medicines and medical supplies under PPA 2011 and its Regulations.** The Regulations made under the PPA 2011 have provisions dealing with procurement of medicines and medical supplies, including maintaining a list of catalogue items to be published on a yearly basis in the Tenders Portal and Journal managed by PPRA. The MSD is mandated to arrange for procurement of catalogue items. MSD may through framework agreements, source catalogue items by placing call-off orders; such framework agreements, should be of no more than three years. Under this arrangement, the procuring entities are required to place orders to MSD for any item included in the price catalogue within one working day of reaching the buffer stock. In the event that the catalogue items requested are not available, MSD is required within one working day of receipt of the request to issue a non-availability (out of stock) notice to the procuring entities so that they can opt for another appropriate procurement method.

10. **Procurement arrangements of medicines and medical supplies at the facility levels:** In principle, no procurement of medicine and medical supplies is undertaken at the facility level. MSD is charged with responsibility of procuring medicines and medical suppliers and distributing directly to government hospitals including accredited private referral hospitals/facility, district hospitals, health centers and dispensaries. LGAs undertake procurement of medicines and medical supplies only when they receive the non-availability notice from MSD and procure using the funds allocated in their budget. In this case, after receiving such notice, facilities channel their requirements to DMO who consolidates all requirements including district hospitals' requirements

prior to forwarding the same to the District Executive Director (DED) for sanction and subsequent submission to PMU for processing. PMUs are responsible for managing all procurement of medicines and medical supplies. During the assessment, it was noted that medicines and medical supplies are procured from private vendors through competitive quotations as a default method from the pre-qualified suppliers by LGAs.

B. Program Fiduciary Performance

Financial Management Risk Consideration

i. Planning and Budgeting

Overall FM objective - the program budget is realistic, is prepared with due regard to government policy, and is implemented in an orderly and predictable manner.

11. The planning and budget preparation processes are considered reasonably participatory and adequate for the program. The main shortcoming established during the assessment is the (very) late availability of budget ceilings from the MoF contrary to requirements of the budget guidelines. Furthermore it was noted that facilities have inadequate knowledge on planning, budgeting, monitoring and reporting. The CCHP Guidelines do not include revenue budget, and therefore facilities are not required to prepare revenue budgets. Staff and members of facility governing committees therefore will require capacity building in planning, budget preparation, monitoring and reporting, including the use of the Planning and Reporting tool (PlanRep). In addition, the PlanRep structure will need to be adapted to recognize primary health facilities as budgeting entities.

ii. Accounting and Financial Reporting

Overall FM objective - adequate program records are maintained, and financial reports produced and disseminated for decision-making, management, and program reporting.

12. The accounting policies and procedures for both central and local government (Local Government Accounting Manual) are robust but there is the need to enhance the skills of staff, especially at LGAs on how to utilize them effectively whilst producing accounts. The Epicor accounting software produces financial statements but at local government level it needs its chart of accounts to be revised as it cannot show which Development Partner is funding the program. In addition, the connectivity of the Epicor system needs to be improved as it creates inefficiency in producing accounts. There is also a need to activate the asset management module of the system in order to record assets on the system and compute depreciation. The PlanRep tool is used for planning and budgeting at the LGAs but once the budget is complete, the tool cannot automatically upload the budget to Epicor. This is manually done and subject to errors. In order to address the matter, the installation of an integrator for the two systems is currently being worked on. Finally, the reporting module for Epicor needs to be enhanced in order to produce useful reports for management to take action.

13. Given that this will be a large and complex program covering the whole country, there is a risk that there will be delays in submission of accurate financial reports given that there could be communication challenges between the Health Facilities and the LGAs. There will be a need to

train staff in order to enhance their skills in planning and reporting. Also, PMO-RALG and MOHSW should jointly develop (i) appropriate standardized reporting templates to capture FM data required for program monitoring and (ii) an annual action plan.

14. LGAs do not have adequate capacity in terms of staff numbers, skills and working tools, e.g. computers and vehicles for effective discharge of their duties given that they will have to visit health facilities to conduct supervision. Staff technical skills in accounting should be strengthened and working tools provided to address this issue. In accordance with the recent Establishment Order, employment of accounting technicians has commenced. These technicians will provide first line FM support to health facilities and bridge the existing supervision gap between council headquarter and facilities. These technicians will need to be equipped for movement around facilities under their jurisdiction, preferably by paying them a monthly tax-free transport allowance.

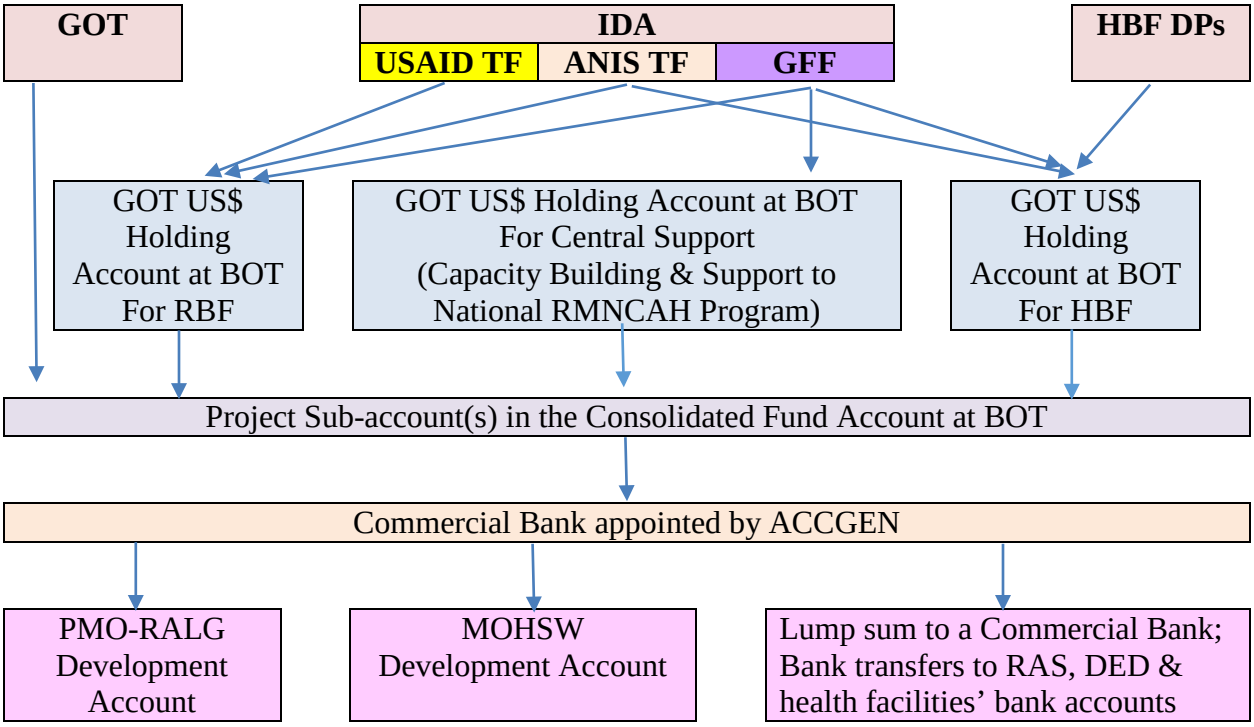
iii. Treasury Management and Funds Flow

Overall FM objective - adequate and timely funds are available to finance program implementation.

15. No designated or special accounts will be needed for this operation. Funds will flow from IDA and World Bank-managed trust funds into three separate government-owned holding accounts for (i) HBF, (ii) RBF, and (iii) central support respectively. All of them are at the BOT and denominated in United States Dollars. From there funds will be transferred to the consolidated fund sub-account for the program denominated in local currency also at the BoT. MoHSW, PMO-RALG, LGAs and health facilities will be paid through the Exchequer Issue Notification and transfers from the consolidated fund sub-account for the program will be made directly to their bank accounts mainly held by commercial banks. Payments will then be made from these accounts. The details of the holding accounts for HBF, RBF and central support as well as the consolidated fund sub-account at BoT and their signatories should be submitted to the Bank between the signing of the Credit and its effectiveness. The opening of bank accounts at MoHSW, PMO-RALG, LGAs and HFs should be in line with the existing government guidelines as issued by the Accountant General. The chart of accounts in Epicor will need to be expanded to incorporate individual facility bank accounts in order to capture funds transfers as revenue and payments as expenditure. This will make it easier for audit verification of program funded transactions.

16. The FM assessment revealed instances of delays in release of funds from Treasury to LGAs. On average funds take at least 30 days to reach the LGAs as opposed to the standard 14 days. There is need to adhere to specific disbursement timelines for all actors and implementing institutions within which action(s) must be taken or actual disbursement must take place provided funds are available for program implementation and disbursement conditions fulfilled. There is concern regarding the unpredictable nature of releases by the Ministry of Finance (MoF). Without reasonable predictability, it is difficult to plan. MoF needs to ensure regularity in funds releases by committing to transfer funds on a quarterly basis. PMO-RALG should monitor this and ensure prompt transfer of own source funds to health facilities by LGAs.

Figure 13: Funds Flow Diagram for the Program

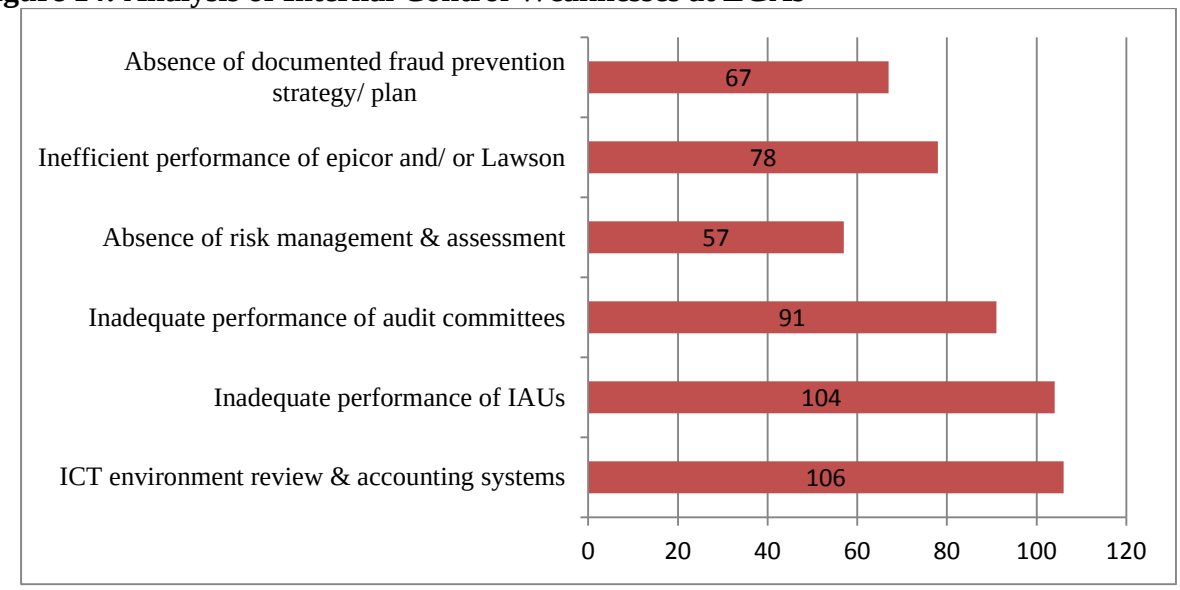


iv. Internal Controls (including Internal Audit)

Overall FM element objective - There are satisfactory arrangements to monitor, evaluate, and validate program results and to exercise control over and stewardship of program funds.

17. The basis for internal control procedures in LGAs is: the Local Authority Accounting Manual (LAAM) of 2009 and the Local Authority Financial Memorandum (LAFM) of 2010. The two documents set out detailed processes to be followed and documentation necessary for comprehensive accounting system, segregation of duties, approval hierarchies and filing of documents. However, in view of regular observations made and audit issues raised by the Controller and Auditor General in annual reports, recommended procedures are not always adhered to. The figure below presents an evaluation of internal control systems and good governance issues at LGAs for the year 2012/2013.

Figure 14: Analysis of Internal Control Weaknesses at LGAs



Source: Controller and Auditor General External Audit Report on Local Government Authorities FY 2012/2013.

18. The government has taken a number of initiatives to address non-compliance and strengthen oversight to ensure that audit findings are addressed timely and adequately by ministries and LGAs. Steps taken include creation of an internal audit unit in each ministry and LGA and the appointment of the Internal Auditor General with five assistants, including an Assistant Internal Auditor General responsible for LGAs; and strengthening of the three parliamentary oversight committees which include: the Public Accounts Committee (PAC), the Local Authorities Accounts Committee (LAAC), and the PMO-RALG Audit Committee have also been strengthened in terms of training and providing adequate funds for PAC to carry out its duties. However, despite having internal audit units, a number of challenges remain; they include internal auditors not having access to Epicor 9.05 and therefore not able to audit the system.

19. A review of internal audit units at the LGA level revealed they were under-resourced in terms number of staff, skills and working tools. Very few internal auditors had professional qualifications and, in all visited councils, internal audit was regarded as an accounting discipline hence the need to sensitize LGAs about the role of internal audit. Furthermore, council audit committees were noted to be generally weak and ineffective. PMO-RALG needs to review the composition and structure of audit committee at LGAs to enhance independence and quality of membership.

v. External Audit

Overall FM objective - adequate independent audit and verification arrangements are in place and take account of the country context and the nature and overall risk assessment of the program.

20. The Public Audit Act No. 11 of 2008 grants the Controller and Auditor General (CAG) sole responsibility for statutory audit of all MDAs and LGAs [36]. CAG discharges this responsibility either directly or through private auditors contracted as agents. Outsourcing of the audits partly solves the challenge of staff constraints at the CAG office. The CAG has regularly carried out external audits on time and issued reports within nine months of the year end, as stipulated under the law. The program will need to budget for the audit of health facilities using private audit firms. As noted in the PEFA indicators, there are delays in the scrutiny of CAG's reports by relevant parliamentary committees that need to be improved on. Audit terms of reference should be agreed on an annual basis between CAG, MoHSW, PMO-RALG, LGAs and IDA to ensure there is an agreeable scope coverage given the risk of the program. Should there be need to conduct other forms of audit, e.g. forensic and value for money audits, these will be done by CAG that has departments handling these types of audit.

C. Procurement Risk Considerations

21. Main areas of significant risk to the program are: inadequate staffing in LGAs specifically in the procurement and internal audit unit; staff have inadequate knowledge of PPA 2011 and its regulations, planning, bidding documents & request for proposals preparation and evaluation of bids/proposals; and inefficiencies in managing procurement processes, delays in vetting contracts above TZS 50 million by the AG; weak records filing and management system and weak contract management. These risks will need to be addressed, monitored and evaluated throughout the program.

22. **Procurement Planning**. The PPA and its regulations require all procuring entities to prepare annual procurement plans linked with annual work plan and budget. It is also mandatory for procuring entities to advertise the Annual Procurement Plans in the form of general procurement notice in the newspapers and submit a copy to PPRA for publishing in its website and for monitoring purpose. Based on the data gathered from LGAs visited, the average volume of procurement per LGA is about Tsh 10 billion or US$5 million per annum covering all sectors including health. This volume is translated into about 100 packages for goods, works and non-consultant services per year with most of the packages not exceeding the value of US$500,000.00. During the assessment, it was noted that planning of procurement of medicines and medical supplies commence at the district hospitals, health centers and dispensaries level whereby each hospital, health center and dispensary identify their needs. The aggregation of medicines and medical supplies to be procured for the financial year is done at the district level and included in the LGAs' procurement plans ready for submission to the responsible ministry for final compilation before tabling to the budgetary parliament. The Bank's assessment found that most of the plans are not comprehensively prepared, user requirements are included in the APP with no

[36] Audit at LGAs is governed by the Local Government Finances Act No.9 of 1982 (revised 2000) which stipulates that accounts of every LGA shall be audited by the National Audit Office (NAO)

aggregation, mixing of the templates for works/goods and consultancy services, some of the APP include non-procurable items.

23. **Procurement Markets and Practices**. PPRA is registering suppliers and service providers doing business with the public sector and post the same to its website. By September 2013, only 324 suppliers and service providers had been registered since the system for registration was introduced; only 10 (3%) of these are suppliers of medicines and medical supplies and equipment. It was observed that LGAs are using shortlisted suppliers pre-qualified through NCB. However, there are legal requirements that pharmaceuticals have to be registered with the Tanzania Food and Drugs Authority (TDFA). Most of the pharmaceutical products in the country are imported by MSD and the law requires that any person dealing with importation of the products must be registered by TFDA.

24. **Procurement Processes and Procedures.** The PPA and its associated regulations require procuring entities wishing to commence competitive tendering to provide all eligible bidders with timely and adequate notification of the procuring entity's requirements and an equal opportunity to tender for the required goods, works or services. The regulations spell out the contents of invitation to tender and it is mandatory that invitations to tender be made in writing. The format of advertisement used to publish the advertisement is issued by PPRA and it contains adequate information to the prospective bidders to make decision to participate. It is mandatory that the solicitation documents be issued immediately after first publication of the tender notice to all bidders who respond to the tender notice. Under PPA 2011, it is mandatory for procuring entities to prepare a tender notice for national and international tenders and submit the same to PPRA for publication in the Journal and Tenders Portal.

25. Bidding Documents used are those developed by PPRA including: (i) standard bidding documents for the procurement of goods, works, and non-consulting services as well as standard request for quotations; (ii) request for proposal for selection and employment of consultants; and (iii) guidelines for evaluation of bids and proposals. The PPRA has revised all standard bidding documents, guidelines and working tools to align them with the provision of PPA 2011 and its regulations. The standard bidding documents issued by PPRA have been reviewed and found to be acceptable to the Bank with some exception on NCB procedures. However, the challenge has been to customize the bidding documents to suit the requirements of a particular procurement. Generally all the LGAs are using these bidding documents. As for the specifications for medicines and medical supplies, LGAs rely on the specifications and catalogue issued by MSD. In terms of specifications especially for works contracts, LGAs rely very much on the specification issued by the Ministry of Works with minor modifications depending on the circumstance.

26. Bids evaluations are carried out by an evaluation committee constituted according to the PPA and it Regulations. Evaluation committee comprises members from the user departments, technical staff and sometimes from outside the LGAs where expertise is lacking internally. Generally, evaluations follow the evaluation/qualification criteria specified in the bidding documents. However, the following weaknesses were noted in the reviewed sample; post-qualification criteria are used in the preliminary stage; bids are rejected for being below engineer's estimate (works tenders); attachments such as a copy of advertisement and minutes of bids opening are not attached.

27. **Distribution of medicines and medical supplies, storage and inventory management.** Procurement of bulk medicines and medical supplies is done by MSD headquarter through nine strategic zonal centers. The inspection and quality assurance of deliveries from suppliers is carried out at MSD laboratories. The zonal stores have the responsibility of delivering medicines and medical supplies to the respective hospitals, health centers and dispensaries in accordance with the schedule agreed between the end users and MSD. The assessment revealed that MSD is not issuing non-availability notice within one day as provided in the PPA 2011 and its Regulations 2013. Hospitals, health centers and dispensaries normally receive non-availability notice when medicines are delivered as the notice is contained in the delivery notes which indicate items that are out of stock.

28. The inspection of the delivered medicines and medical supplies at the level of district hospitals is done by the Therapeutic Committee while at the health centers and dispensaries it is done by the Health Facility Governing Committee. Generally, there is no robust quality assurance system at the facilities level for the medicines supplied by private vendors apart from visual inspection and quantity verification. The main challenge noted by the assessment team was inadequate space/room for safe and proper storage of medicines. The assessment team observed lack of internal and external control mechanisms for inventory management. There was no evidence to attest whether stock-takings at the facility level were done regularly.

29. **Inefficiency within User Departments, PMUs and Tender Boards**. Significant delays have been noted in processing procurement. Timelines indicated in the procurement plans are not followed and procurement processes are not initiated on time due to delays in preparing specifications, statement of requirement or terms of reference. Critical areas with inefficiencies included processing of requirements from user departments, preparing tender documents, delays in appointing evaluation committees, reviewing tender evaluation reports and preparing contract documents. The main reasons for inefficiencies within PMUs include: excessive ad hoc procurement due to poor planning; inadequate staff in PMUs; inadequate knowledge and experience in procurement matters for some of the PMUs staff; lack of experienced technical staff within PMUs (inappropriate staff composition); inappropriate PMUs structure; and weak procurement records management systems. The main reasons for inefficiencies within Tender Boards include: inadequate knowledge of PPA and its regulations, and absence of members to form a quorum for the meetings of the tender board. Inefficiencies of these organs lead to bids being awarded after expiration of bids validity period and delays in service delivery and implementation of projects.

30. Transparency is among the fundamental pillars of public procurement and disclosure of information is one of the elements of transparency. On average in about 40% of the tenders awarded, unsuccessful bidders were not informed on the award decisions and publications of awards were not published on LGA's notice board or availed to PPRA. The law requires PPRA to publish contracts awarded in its Journal and Tender Portal, the names of those who have been awarded the contracts, contract amount, the date when the awards were made, contracts period and final contracts amount. For PPRA to fulfill this requirement procuring entities are required to notify PPRA on the awarded contracts for further publishing. However, from PPRA's audit reports the compliance on the publication of contract awards still a problem.

31. **Framework Agreements for Common Use Items and Services (CUIS) under GPSA**. Most of the goods/services in the LGAs are procured through Common Used Items Systems (CUIS) under Framework Agreements introduced by the Government. The Government in February 2011 established the Government Procurement Services Agency (GPSA) to be responsible for overseeing the implementation of the CUIS throughout the country. According to PPRA's performance report FY 2012/13, there is a decline in the use of the system. Some of the challenges for implementing the system are; lack of adequate knowledge by some suppliers and service providers to prepare bidding documents which leads to submission of non-responsive bids; some procuring entities do not use the system, especially LGAs which still advertise tenders for CUIS; inadequate enforcement measures for those who do not use the system as well as service providers failing to execute call off orders at contractual prices, demanding a price increase within the validity of signed contract; while some service providers were reluctant to give their prices because they are not sensitized enough to understand advantages of the system.

32. **Controls and Integrity**. Procurement oversight at PMO-RALG, MoHSW, MSD and LGAs is done by Internal Auditors, PPRA and Controller and Auditor General (CAG). Internal Auditors in LGAs prepare quarterly audit reports which do not cover procurement issues adequately. According to PPA 2011, the Internal Auditor is required to state in his/her report whether the Act and Regulations have been complied with; and the Accounting Officer of the procuring entity after receiving the report is required to submit such report to PPRA within 14 days. Upon receiving the report, PPRA may, if it considers necessary, require the Accounting Officer to submit a detailed report on any procurement implemented in violation of the Act and Regulations for review and necessary action. It was observed that this provision is not being complied with by procuring entities as most of them are unaware of the requirement. It was noted that most of the Internal Auditors are not conversant with provisions of the PPA and its Regulations and most of the units are understaffed.

33. **Audits.** Procurement audits carried out by PPRA evaluate the compliance level and detect corruption using the 13 performance indicators and Red Flags Checklist. Results of procurement audits and VFM are published in local newspapers and PPRA's website. Accounting Officers of non-performing procuring entities are summoned by PPRA's Board of Directors to discuss the findings and corrective measures to improve compliance in their entities.

34. **Procurement Capacity**. In all LGAs visited there were procurement officers although the number of staff is inadequate to match procurement volumes. Currently, experience of procurement officers vary significantly from one LGA to another as there are LGAs with officers with experience and others with junior officers with no adequate experience. Due to lack of adequate number of staff in most of the LGAs, PMU members are drawn from different user departments to form ad-hoc committees to handle procurement issues, contrary to the requirement of the PPA. Generally, the assessment revealed that there is inadequate knowledge in the application of provisions of the newly enacted PPA 2011 and its regulations.

35. **Records Keeping**. The PPA and its regulations prescribe procurement records that should be maintained and archived by a procuring entity; these include procurement proceedings and decisions taken and the reasons for those decisions. The records range from planning to contract closure and to be kept for five years after contract closure. Generally, records in the LGAs are scattered, incomplete, with no proper filing and management system. PMUs are maintaining and

archiving records of tendering process while account departments are maintaining payments records, and user departments are maintaining and archiving contract management records with consequent difficulties to trace records of particular tender in one file. There is inadequate space for PMU staff and documents storage.

D. Fraud and Corruption Analysis

36. The Prevention and Combat of Corruption Bureau (PCCB) was established under the Prevention and Combating of Corruption Act. No. 11 of 2007 (PCCA 11/2007) and came into force on July 1, 2007. The overall performance of the PCCB in terms of allegations and cases handled is reflected in the table below. As the table below shows, the government's convictions rates are low in most corruption cases, compared to the number of cases investigated as compared to corruption cases in other countries. In Kenya, the Ethics and Anti-Corruption Commission prosecuted 222 cases and obtained a conviction in 172 cases in 2014. Further, it is clear that the courts are still dealing with a big backlog of cases from previous years, than the number of current year's cases.

Table 29: Analysis of Allegations Received and Cases Investigated

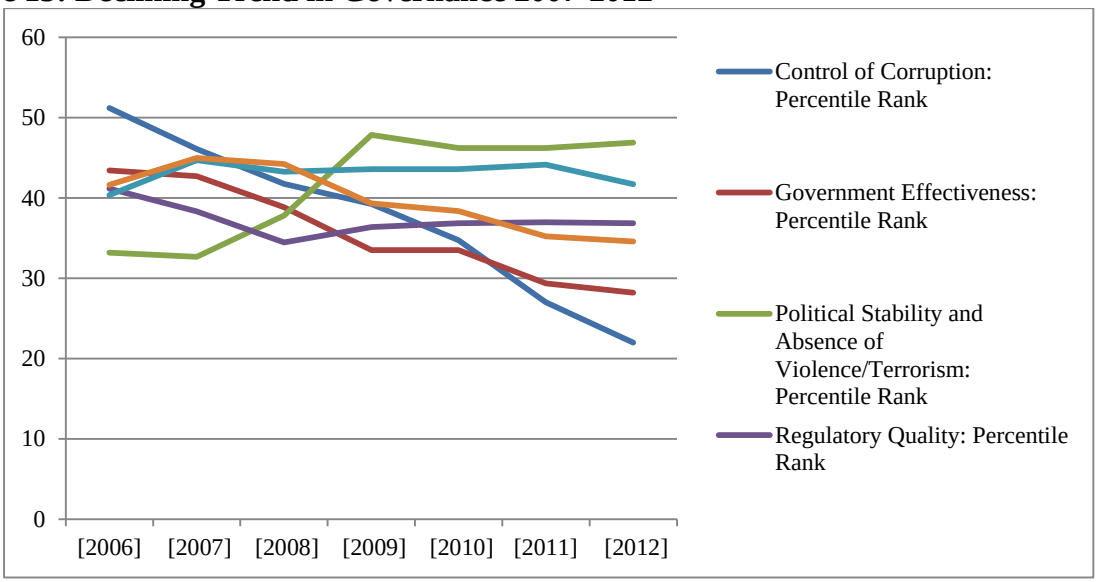
Year	Allegations received	Cases Investigated	Admin actions taken	New cases in court	Total cases prosecuted	Convictions	% of convictions compared to cases investigated	Assets recovered (in Tsh billion)
2011	4,765	819	30	193	709	52	6%	4.6
2012	5084	1178	27	288	723	47	4%	9.7
2013	5,456	1,100	19	343	894	89	8%	4.2
2014*	2,765	391	6	166	837	87		

*January to June 2015

***Source**: PCCB Head office, September 2014*

37. Over the past six years, the major international indices have shown that the governance environment in Tanzania has weakened. The Worldwide Governance Indicators (WGI) show a declining trend between 2007 and 2012 for four out of six governance indicators. With the exception of political stability and absence of violence, and regulatory quality the other indicators including government effectiveness, voice and accountability, rule of law and corruption have been declining. Recent statistics (2014) released by The Global Corruption Barometer, World Wide Economic Forum (Executive Opinion Survey), World Governance Indicators and Ibrahim Index on Africa Governance, all show a further decline in relation to control of corruption. Transparency International, on the other hand, shows there is a slight improvement in the county's ranking of corruption from 35.5 in 2013 to 38.9 in 2014. Overall, there is a weak political will to fight grand corruption and, in most cases, corruption in service delivery is widespread and attempts to mitigate it have not been successful.

Figure 15: Declining Trend in Governance 2007-2012



Source: Worldwide Governance Indicators (2014)

i. Fraud and Corruption Risks

38. Based on the fiduciary risks identified in this FSA, and assuming that most of expenditures and procurement will take place at MoHSW, PMO-RALG, and LGA level, the main corresponding fraud and corruption (F&C) risks for this operation are the following: (i) collusion and fraud during procurement; and (ii) misappropriation of funds. The main risks are related to: FM: (a) weak internal controls at LGA level (low levels of training, access to Epicor, working tools and budget to carry out their responsibilities and weak oversight by facility board); (b) lack of adequate levels of staff at LGA level; and (c) inadequate information on budgets and expenditures available to facility managers. For procurement, risks include: (a) splitting of tenders, (b) delays in bid evaluations, including adjudication of evaluation reports and awards recommendations; (c) weaknesses in publication of contract awards; (d) poor record keeping; and (e) weak contract management. Evidence provided in this FSA on procurement controls and integrity seems inconclusive, so it is difficult at this point to ascertain the implications for F&C. F&C risks at LGA level related to FM and Procurement should be considered "high", especially considering the program is nationwide. Risks related to MoHSW and PMORALG are considered substantial.

39. Based on the current information, overall F&C risks appear as "high" in particular in a weak environment in terms of control of fraud and corruption. Mitigation measures for lowering these risks, as well, as the risks of detection of fraud and corruption are detailed below to include (a) strengthening the facility boards/committees oversight of service delivery, and (b)strengthening the complaints and handling mechanism.

ii. Facility Boards/Committees

40. Each health facility is governed by a board or committee that is responsible for providing oversight of the health services provided. The functionality of this board/committee is often poor with meetings that are supposed to be held quarterly rarely taking place and records not kept or

shared with the district management. The members of the board/committee are also poorly informed about their role. Strengthening the functioning of facility boards/committees is essential in improving accountability for service delivery at the facility level. In addition, the boards/committees need adequate information on budgets, staffing and other service delivery inputs to be able to carry out their oversight role effectively. This will help to ensure that the facilities performance is reported to the community representatives, District management is able to track the facilities performance and hence make supervisory visits more meaningful. Overall, well-functioning facility boards/committees should be able to raise concerns on the quality of services to management and to ensure they are addressed.

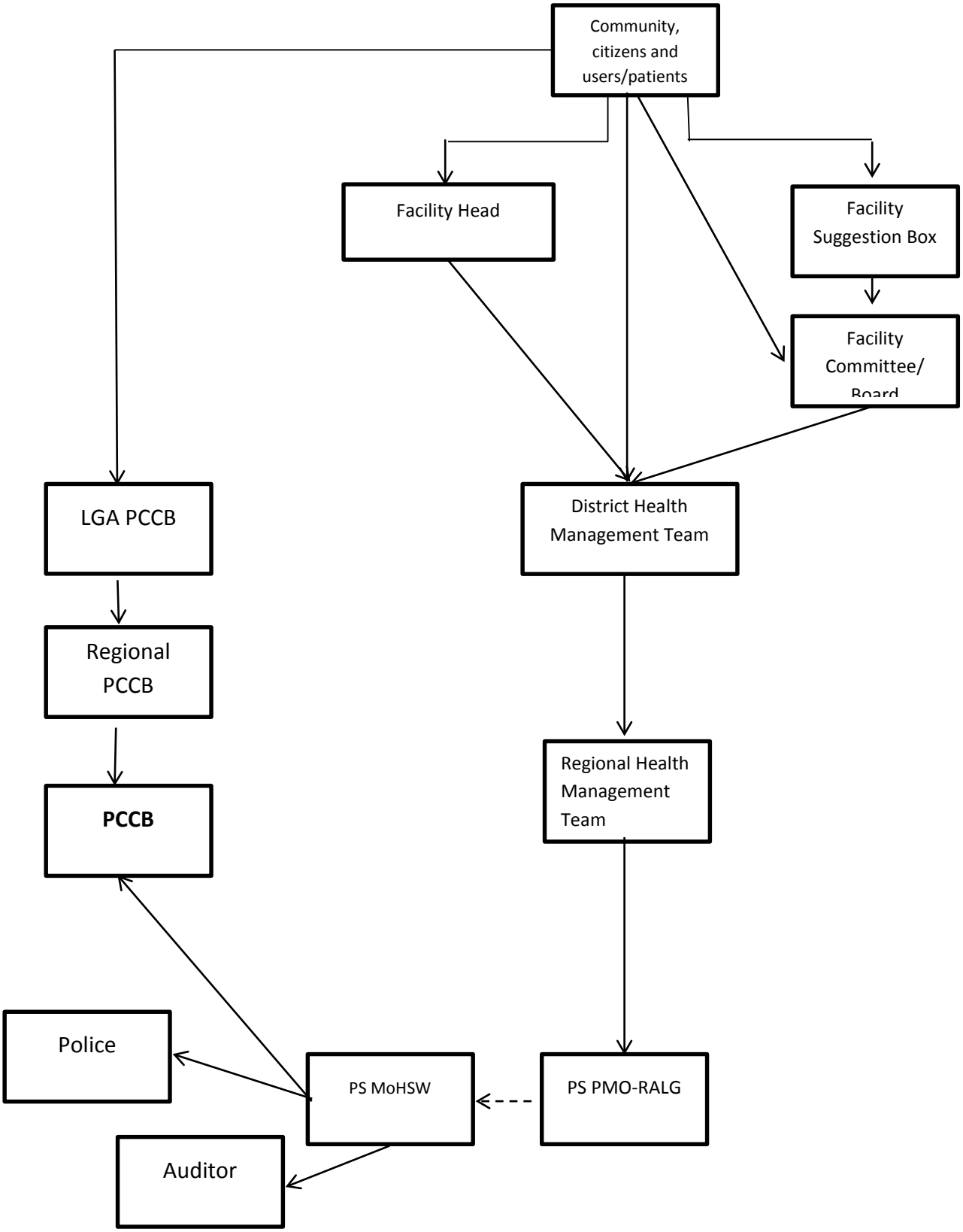
iii. Complaint Handling Mechanisms

41. The public sector in Tanzania has regulations that mandate different organizations including service delivery facilities at different levels, to handle complaints. However, these mandates are not always followed in practice. Visits conducted as part of the fiduciary assessments to LGAs and health facilities revealed that there are constraints to effective implementation of these mechanisms at the facility level, including knowledge of the system functionality, conflict of interest in handling of suggestion boxes, shortage of staff dedicated to handle complaints and absence of complaints register. At the Ministry of Health and Social Welfare headquarters, PMO-RALG headquarters and at the local government authorities however, the complaints handling mechanism (CHM) are functional, but at this level, they have no significant impact on health services complaints which arise at the hospitals, health centers and dispensaries. Few of the health facilities have a functioning CHM.

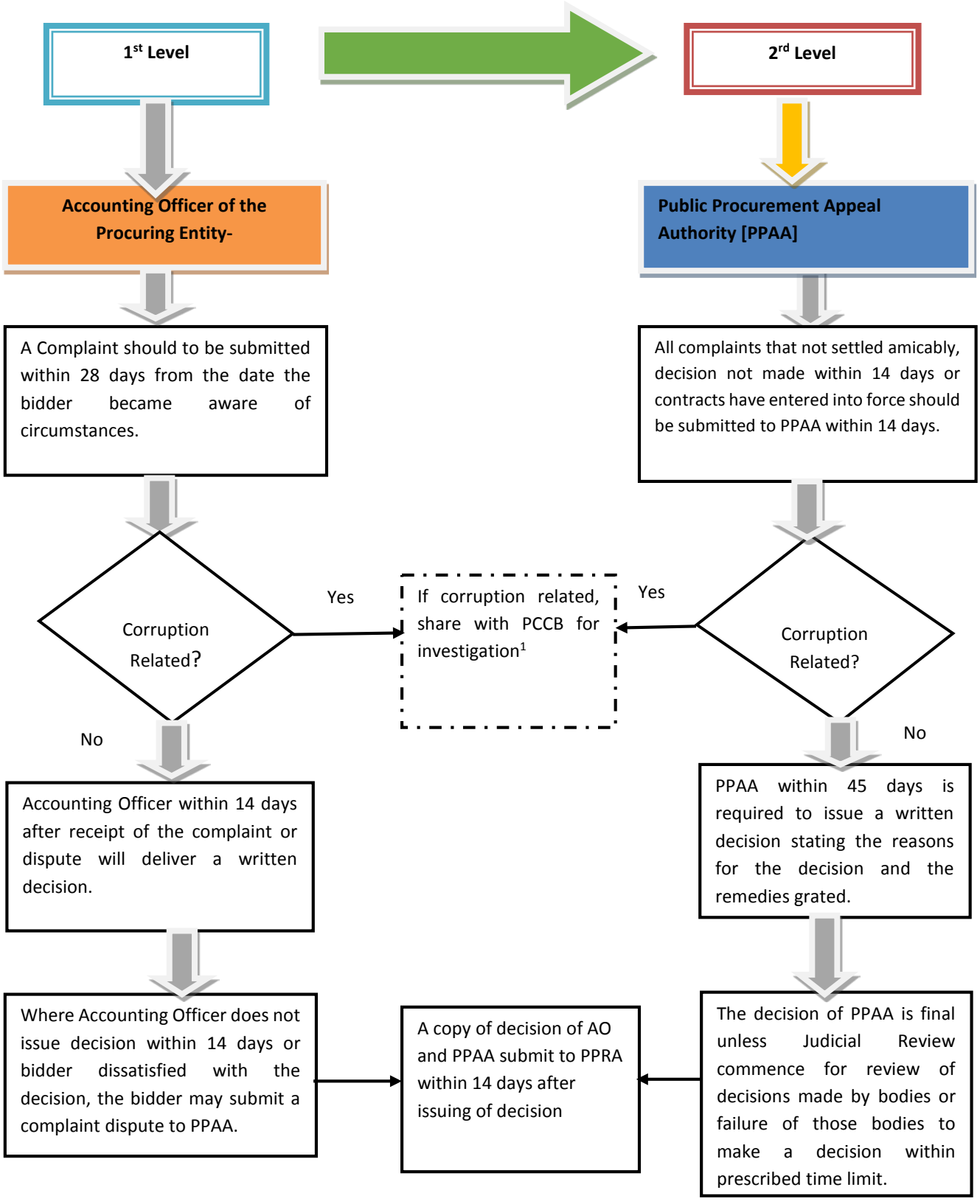
42. For the purpose of this PforR, the existing CHM mechanisms will be strengthened. The objective should be to strengthen the oversight committees at the level of the health center and hospitals to ensure that they provide appropriate oversight of the health service including ensuring a functioning CHM is in place. All complaints will be reported to the Council Health Management Team. For F&C complaints, the Council Health Management Team will send them directly to PCCB, which is independent and well resourced. Complaints unrelated to F&C will be sent to the Council Health Management Team which should be tasked with reporting them to the PMO-RALG, following the existing bureaucratic channels. In addition, as part of the programs information, education and communication campaign, the program will inform potential users of the CHM the essential features of the system and how to access it. There is a separate complaint handling mechanism for procurement.

On complaints purely related to procurement, the Committee would forward it to the procuring entity with an instruction to respond to the complainant with a copy to the Committee and the Chairperson of the Health Facility Board. Bidders not happy with the response from the procuring entity will appeal directly to the Public Procurement Appeals Authority (PPAA) who will listen to each party and make a determination. The party which will not be satisfied with the determination of the PPAA may seek a Judicial Review. One point the public raises is the absence of mechanism to know if a complaint is addressed at all, other than corruption cases that go to court. Flow Chart 2 depicts the summary of how a procurement complaint should be handled for the procurements at Health Facilities level.

Flow Chart 1: Complaint Handling Mechanisms for SPHCR



Flow Chart 2: Review of Procurement Complaints as per PPA 2011 and its Regulations 2013 (Two-tier System)



iv. Alignment with Anti-Corruption Guidelines for PforR Operations

1. Sharing of Debarment list of firms and individuals

43. The Government of Tanzania commits to use the Bank's debarment list to ensure that persons or entities debarred or suspended by the Bank are not awarded a contract under the Program during the period of such debarment or suspension. Companies and individuals debarred by the Bank will be posted and updated regularly on the MOHSW (www.moe.go.tz) and the PMO-RALG websites (www.pmoralg.go.tz), and advertised publicly by MOHSW. Both entities would take responsibility in ensuring that their websites are updated regularly with information on the list of debarred firms and individuals and share this information with all procuring entities in the Program, instructing them to comply by appending the debarment list to the annual transfer of grant notification which will be made public - and go to all health facilities in the program.

44. In addition, the government also agreed that they would include some disclosure measures in bidding documents for works, goods and services to be financed under the program, including insisting that the firms and/or individuals declare they have not been debarred or suspended and/or have any links with a debarred entity or individual.

2. Sharing information on fraud and corruption allegations

45. In line with the ACGs, the government (through MOHSW) will share with the Bank all information on fraud and corruption allegations, investigations and actions taken on the Program, including on procurement as needed. The Bank has been informed that under Tanzania's legal system, the primary agency for investigating corruption is the Prevention and Combating of Corruption Bureau (PCCB). Where PCCB investigations reveal that a given case is primarily one of fraud rather than corruption, the PCCB refers it to the police for further investigation and prosecution. In this context, fraud and corruption allegations made in respect of program funds will be referred by the beneficiaries to the district offices of the PCCB. The PCCB gets monthly reports from the regional offices on fraud and corruption and other relevant activities, but in the case of this program, the PCCB would compile and share information on fraud and corruption annually to MOHSW who will share with the Bank. The details of this reporting would include the types of allegations and the status of actions taken. A template for recording and sharing the information with the Bank has been provided to the PCCB.

3. Investigations of fraud and corruption allegations

46. The GOT has advised that (i) the Prevention and Combating of Corruption Act permits the PCCB to cooperate and collaborate with the Bank in the fight against corruption, and permits the PCCB and the Bank to undertake joint investigations of sanctionable practices if and when the parties so agree; (ii) the Bank may also undertake its own investigations of F&C allegations under the Program. In this context, the investigation of F&C allegations under the Program will be handled through three possible modalities, depending on circumstances: (i) the PCCB will undertake its own independent corruption investigations arising from allegations reported to it as detailed above; (ii) the PCCB and INT will undertake joint corruption investigations. The initiation, scope and operational procedures will be decided on a case-by-case basis by PCCB and INT; and (iii) INT will undertake its own F&C investigations. To this extent, program participation agreements to be entered into between MOHSW and PMO-RALG will ensure that both entities

and INT are able to acquire all records and documentation that they may reasonably request from the program implementation units regarding the use of program funding.

E. Fiduciary Risk and Mitigation Measures

Fiduciary Risk	Description	Mitigation Measures	Due Date	Responsibility
Program Level	Coordination due to the large number of entities involved. Ensuring funds are used for purposes intended will be a challenge.	Appoint Sector Technical and Program Steering Committees to provide oversight in ensuring smooth program coordination at all levels. Establish a Program Coordination Unit that includes members from PMO-RALG which will be responsible of providing overall supervision.	Completed	MoHSW and PMORALG
	Weak fiduciary capacity in all fiduciary aspects highlighted below	Provide targeted capacity building to all fiduciary staff at all levels.	Within 12 months of project implementation	
Financial Management Risk				
Planning and Budgeting	Unfunded budgets Absence of reliable cash-flows affecting implementation of planned activities PlanRep may not automatically upload the budget to Epicor requiring it to be manually done which is subject to errors and delays.	Earmark SPHCR funds using accounting codes at the Consolidated Fund using a sub-account for the project under MoHSW.	Within 12 months of project implementation.	MoHSW, MoF and PMO-RALG
		Prepare reliable cash flow budgets.	Quarterly.	
		The acquisition and installation of an integrator to link the PlanReP and Epicor for automatic uploading of budgets onto Epicor is currently in progress.	Within 12 months of project implementation	
Accounting and Financial Reporting	Funds not being used for purpose intended	Put in place FM systems and guidelines at HCF level.	Within 12 months of project implementation	MoHSW, PMO-RALG and MoF
		The Establishment Order to employ accounting technicians who will be responsible for FM at the facility level has already being issued. These technicians will need to also be trained.		
	The chart of accounts may not show which Development Partner is funding the program when funds are sent to the LGA hence not able to prepare accountability	Revise the chart of accounts.		

Fiduciary Risk	Description	Mitigation Measures	Due Date	Responsibility
	for a Development Partner's funding.			
	Poor connectivity between the LGAs and the central servers.	Strengthen the connectivity in Epicor in order to efficiently use the system.		
	Failure to record assets at all levels.	Activate the asset management module.		
	Epicor 9.05 not able to generate annual financial statement and management reports.	Enhance financial reporting module for Epicor in order to produce useful reports for management to take action.		
	Delays in submission of various financial reports.	Train staff who consistently send reports late to enhance their skills as well as closely monitor them at both health facility and LGA levels to ensure timely financial reports are received.	Annually	
	Absence of book-keeping skills at HCF is going to impact maintenance of reliable financial records.	The hiring of accounting technicians to assist HCFs on an-ongoing basis to supplement limited capacity of LGAs has already commenced.	Within 12 months of project implementation	
Treasury Management and Funds Flow	Not all HCFs will have bank accounts	Bank accounts are opened by all HCFs before funds are disbursed.	Before funds are disbursed to HCFs	MoF, MoHSW, PMO-RALG, LGAs & HCFs
	Delays in release of funds from MoF to ministries, LGAs and HCFs.	Monitor the budget approval process and endorsement by the Parliament now tabled in April to June each year.	Annually	
	Irregular release of funds by the Ministry of Finance to LGAs and HCFs.	Request GoT commitment to ensure release of funds to Program on a quarterly basis.		
	Delayed release of funds from LGAs to HCFs.	LGAs & HCFs to display amounts transferred to them on their notice boards and their websites.		
	Funds may not be used efficiently and effectively to achieve the purposes for which intended	Carry out value for money audits	Midterm and six months prior to the end of program	

Fiduciary Risk	Description	Mitigation Measures	Due Date	Responsibility
Internal Controls (including Internal Audit)	Non-compliance with internal control systems at both central and local government levels.	Skills of audit committees and internal auditors will be enhanced to effectively monitor compliance of the internal control systems and report on a quarterly basis.	Within 12 months of project implementation	MoHSW, PMO-RALG, MoF and LGAs.
	Weak internal audit function in terms of skills, equipment, lack of access to Epicor system and budget to monitor the internal controls put in place.	Strengthen internal audit units through training and capacity building. Facilitate internal audit units with resources both financial and otherwise. Production of quarterly audit reports. Grant internal auditor's access to Epicor as well as acquisition of internal audit software.	Within 12 months of project implementation and annually thereafter	
External Audit	Failure to audit a reasonable sample of HCFs given the large number of HCFs supported under the Program.	CAG to contract private audit firms to conduct audits on his behalf.	Before end of FY	CAG, MoHSW, PMO-RALG.
	Delayed submission of reports	Early appointment of auditors and agreeing of ToRs. Carrying out of interim audits.		
	Slow scrutiny of CAGs audit reports by the PAC and LAAC which affects the accountability process.	Enhance technical skills of PAC and LAAC in order for them to improve on their efficiency in following up issues raised by CAG's audit reports.		
Procurement Risks				
Procurement Capacity and internal audit function	Inadequate staffing in LGA procurement and internal audit units as well as existing staff have inadequate knowledge of PPA 2011 and its Regulations	Recruit/appoint qualified and experienced staff to fill the gap in the two units and conduct tailored trainings on PPA 2011 and its Regulations and contract management to PMUs and internal audit units	Within 12 months of project implementation	PMO-RALG & PPRA
Records keeping	Weak records management system.	Establish sound records management system in all LGAs and participating MDAs.	Within six months of project implementation	PMO-RALG/LGAs
Procurement Efficiency	Inefficiencies in processing and managing procurement activities.	Ensure procurements are processed as per the timelines in the procurement plans	Throughout project implementation	PMO-RALG, LGAs
Transparency in procurement process	Lack of transparency in processing competitive quotations and	Ensure LGAs abides with all procedures for processing quotations including	Throughout project implementation	PMO-RALG, LGAs and PPRA

Fiduciary Risk	Description	Mitigation Measures	Due Date	Responsibility
	publications of contract awards.	publications of contracts awards as per the PPA.		
Delays arising from vetting of contracts before signature	The Attorney General has no capacity to vet all contracts above TZS 50 million within 21 days prescribed under PPA.	Review the existing threshold with a view to raise vetting thresholds.	Within 12 months of the project implementation	PMO-RALG, AG and PPRA
Weak Contract Management	Inadequate knowledge and skills in contract managements.	Conduct trainings tailored to address the weakness to in the contract management.	Within one year of project implementation and annually thereafter	PMO-RALG, LGAs
Delays in issuing out stock notice to the facilities by MSD	Delays in issuing stock-out notice to the facilities by MSD in order for LGAs to commence procurement process of missing medicines and medical supplies in a timely manner	Establish the system that will ensure out stock notices are issued within one day as prescribed in the PPA 2011 and its Regulations.	Within one year of project implementation	MSD and MoHSW
Fraud and Corruption Risks				
Transparency	A lack of citizen, media and suppliers pressure to eliminate collusive practices due to lack of information.	Publish Clients Service Charters; strengthen government websites to publish timely reports, budget, including quarterly disbursement and execution reports; LGAs and Health Facilities to publish budgets and expenditures in public places. CHMT to provide budget and expenditure data to health facilities to enable them to improve performance.	Within one year of project implementation and annually thereafter	MoHSW, PMO-RALG, LGAs and Health Facilities
Participation	Weak use of feedback and complaints handling mechanisms by stakeholders.	Implement mechanisms or partnerships with civil society organizations to enable citizen to log complaints or register comments and receive responses from central government/Ensure information on SPHCR is easily available to citizens to enable monitoring and feedback.	Within one year of project implementation and annually thereafter	MoHSW and PMO-RALG
Accountability	Weak response from central government and LGAs to citizen complaints and to poor performance on assessment reports.	Strengthen CHMT and Health Facilities service boards; review complaints register and ensure complaints are attended and feedback taken is adequately documented, responded to and posted to MoHSW & PMO-RALG website twice annually. Nominate Complaint Desk Officers at health facility level and for CHMT dedicated exclusively to health concerns.	Within one year of project implementation and annually thereafter	MoHSW, PMO-RALG, LGAs and Health Facilities

F. Overall Fiduciary Risk Rating

47. Based on the above risk analysis, overall fiduciary risk rating is substantial.

Annex 6: Summary Environmental and Social Systems Assessment

1. The World Bank's Program for Results (PforR) operation - ***Strengthening Primary Health Care for Results –*** is supporting the Government of Tanzania's primary health care (PHC) program (2015/16 – 2018/19). The program innovatively links the disbursement of funds directly to the delivery of defined results and builds on increased reliance on borrower safeguard and oversight systems. In terms of environmental and social management, PforR employs a risk management approach, in which process requirements are adapted to the Program context. For each proposed PforR operation, the Bank assesses—at the program level—the borrower's authority and organizational capacity to achieve environmental and social objectives against the range of environmental and social impacts that may be associated with the program. This Environmental and Social Management System Assessment (ESSA) examines Tanzania's existing legal, regulatory, and institutional framework for environmental and social management systems, defines measures to strengthen the system, and integrates those measures into the overall Program. The ESSA has been undertaken to ensure consistency with six core principles outlined in the World Bank's *Operational Policy 9.00 - Program-for-Results Financing*. The ESSA is intended to strengthen the regulatory authority or organizational capacity to effectively manage the program environmental and social risks and promote sustainable development while enhancing performance of the program in managing environmental and social effects.

2. The ESSA process included extensive stakeholder consultations and disclosure of the ESSA Report following the guidelines of the World Bank's Access to Information Policy. The ESSA consultation process is embedded in the program consultation process.

3. The program focuses on improving service delivery and strengthening systems and will also finance civil works related to upgrading and improving infrastructural conditions and utility services of existing primary health care facilities. Program activities are not expected to have significantly adverse environmental footprint, if construction activities and healthcare facility operations are well managed. Impacts are also expected to be moderate since the infrastructure rehabilitation and construction works will be confined to existing PHC premises. The program provides an opportunity to improve due diligence measures related to management of construction related issues, good practices for asbestos management, improved healthcare waste management and incinerator operations, enhancement of sanitation and water supply systems for monitoring and enforcement. Additionally, its programmatic approach to the health sector provides a significant opportunity to improve systemic implementation of environmental practices related to improving infection control practices and health systems functioning and operations at PHC facilities. The program will also focus on enhancing the existing mechanisms for grievance redress and dispute resolution, participatory consultations and feedback for social accountability, along with increasing awareness of environmental health issues and better coordination among various ministries, agencies and donor partners on environmental and social aspects. These will be instituted through targeted resource allocations, including manpower, equipment and funds, updated technical guidelines, focused skills training and capacity building on technical and operational issues as part of the BRN in health interventions.

4. The ESSA analysis presents identifies strengths, gaps and opportunities in Tanzania's environmental and social management system with respect to addressing the environmental and social risks associated with the program. The analysis identifies the following main areas for

action in order to ensure that the program interventions are aligned with the Core Principles 1, 3 and 5 of OP/BP 9.00 applicable to the program: Health Care Waste Management and Social Accountability. These could be further defined during the consultation process and during implementation, as required. The gaps identified through the ESSA and subsequent actions to fill those gaps directly contribute to the program's anticipated results to enhance institutional structures in health.

5. The ESSA identifies the key measures to be taken for improved environmental and social due diligence in the program. These measures are linked closely with the Disbursement-linked Indicators (DLIs) for the PforR operation, specifically: DLI 3 (*which represents performance of maternal, neonatal and child health service delivery at primary health care facility level)*, DLI 4 (*which represents annual performance in Maternal, Neonatal and Child Health service delivery at the local government authorities' level*) and DLI 7 (*Completion of annual capacity building activities at all levels*). The key measures are defined in Table 30 below.

Table 30: Measures to Strengthen System Performance for Environmental and Social Management

Objective	Strengths and Weaknesses	Measures
Defining the System for Environmental and Social Management	<u>Strengths:</u> Adequate national regulatory framework and technical guidelines for environmental and social due diligence with respect to the program. Existence of environmental and social practices and procedures under existing World Bank funded health program. <u>Weaknesses:</u> Weak implementation of health waste management practices due to financial, human resources and other capacity constraints. Limited awareness of environmental health risks associated with poor quality of water, inadequate sanitation, etc. The program supported by the Bank involves civil works related to upgrade and rehabilitation of existing primary health centers. Some guidelines exist but there are gaps related to categorization of risks, screening, and monitoring as compared to Core Principles of OP/BP 9.00. The requirements for management and use of asbestos need enhancement.	While the program does not have a significant environmental footprint, or land acquisition implications, its programmatic approach to the health sector provides an opportunity to **improve systemic implementation of environmental and social practices** related to the functioning and operations of primary health care (PHC) centers. The ESSA will follow the measures defined in the existing **Environmental and Social Management Framework (ESMF)** prepared as part of the World Bank-financed East Africa Regional Health Systems Strengthening Project (aka East Africa Public Health Network Project), **Healthcare Waste Management Plans** prepared under earlier World Bank financed projects and procedures as set out in the **Healthcare Waste Management Policy Guidelines**, **National Standards and Procedures for Healthcare Waste Management**, and the **Healthcare Waste Management Monitoring Plan,** in order to prepare the program operational manual. The ESMF has been assessed and found to be compliant with OP/BP 9.00 principles but needs more focus on implementation procedures and institutional mechanisms. The process for enhancing existing mechanisms for **grievance redress and complaint handling**, and **inclusive and participatory consultations and feedback for social accountability** also needs improvement. The program will require i**ncreased coordination** among various ministries, agencies and development partners on environmental and social aspects to further support implementation. The process and criteria for **monitoring,**

	Participatory Planning, implementation and monitoring is weak due to capacity related constraints including incentives. Not all health facilities in the country have fully constituted governing committees and where they exist they are not fully functional to able to apply ***social accountability mechanisms*** that include grievance redress. Application of the social accountability (SAc) mechanisms and other participatory tools are isolated and performance on key aspects is dismal. There is low awareness of Council vs Health facility committees' roles and responsibilities including their expected collaboration.	**enforcement and reporting on environmental and social measures** will be part of overall program reporting and data management. **For improved implementation, enforcement and monitoring, procedures defined in the ESMF, HCWM and Community Engagement plans will be included in the Comprehensive Council Health Plans (CCHP).** **The above requirements, processes and systems will also be included in the program operations manual.** **Monitoring and supervision of the ESSA implementation will be part of the World Bank supervision.**
Technical Guidance and Implementation Capacity	<u>Strengths:</u> Technical guidelines and standards for Health Care Waste Management exist. The ESMF identifies construction related impacts and includes well-defined mitigation measures to be implemented during construction. Guidelines for the constitution of Health Facility Governing Committees (HFGC) with stakeholders' representation exist. Guidelines and training program for social accountability mechanisms that include grievance mechanisms exist. <u>Weaknesses:</u> HCWG guidelines and standards have not been systematically implemented. Weak intersectoral coordination around environmental and social issues. Functionality of the HFGCs is limited due to capacity constraints. Social Accountability (SAc) efforts have limited coverage. Implementation of SAc guidelines is limited due to capacity constraints. Participatory Planning, implementation and monitoring is weak.	The ESSA defines the need for improved and updated technical guidance for better waste management (health care and construction), occupational safety and hygiene practices, enhanced transparency and information sharing, grievance redress, and community participation. **Follow up on the implementation of the HCWM and community engagement plans will be a part of World Bank supervision.**

Addressing Capacity Constraints	Weaknesses: The Healthcare Waste Management program is severely ***under-resourced (manpower and funds)*** which prevents it from providing satisfactory oversight. There is *limited capacity and awareness* of environmental health risks associated with poor quality of water, *inadequate sanitation and hygiene*, which prevents adequate attention be paid to these issues. Training on roles and responsibilities of councils is provided only to the committees and not to the community they serve. The existing training program has limited coverage due to financial constraints.	The ESSA identifies capacity building and training actions for improved implementation including infection control, waste management, how to administer social accountability mechanisms and grievances redress and will be built into the program's capacity building plan. **Capacity building for environmental and social actions will be included in the capacity building plan which will be developed early in year 1 of program implementation, as part of the "Foundational Activities" (DLI 1), and included in the operations manual.** **Progress made on capacity building for purposes of implementing the HCWM and community engagement plans will be provided by the verification of DLI 7 and will be part of Bank supervision support.**
Improved systems for Information Disclosure and Stakeholder Consultation	Strengths: There are processes at the local level for handling general grievances and disputes. The Big Results Now has a scoreboard publicly accessible, and results are reported to President's Office. Weaknesses: ***Public disclosure*** of documents for those programs activities requiring a full Environmental and Social Impact Analysis is a government requirement. But the actual process of public review and comments can be onerous and public hearings are at National Environment Management Council's discretion during the ESIA review and approval process. Under the Environment Management Act, there is a procedure related to grievances with respect to decisions about granting the Environmental Impact Assessment certificate. There is no requirement that the government program Environmental and Social Management Plans (ESMP) include a ***mechanism for handling grievances***, though ESMPs in Development Partner-funded programs do tend to include them. It has been difficult to assess if local grievance mechanisms function well in practice to resolve	Accountability and Transparency of institutions are essential to ensure that the benefits of the program reach all beneficiary groups (service users and providers). The ESSA suggests actions to enhancing existing mechanisms for improved **HCWM, complaint handling**, and **inclusive and participatory consultations and feedback** for social accountability along with improved focus on gender and vulnerable groups. The program will also require: **integration of actions with the Government Open Data Partnership and other information disclosure aspects** the program to avail more information to the public; and i**ncreased coordination** led by MoHSW among various ministries, agencies and donor partners on environmental and social aspects to further support implementation; and information sharing through publicly available mechanisms. **The measures to improve information disclosure and stakeholder consultations will be included in the program operations manual.** **During supervision the Bank will monitor information available in the public domain on implementation of HCWM and community engagement activities and their contribution to improved health care services. Information on the progress will be availed to the Bank through the SWAp reporting requirements and schedule.**

	grievances tied to environmental and social impacts. Performance of health facilities on social accountability that includes resolving grievances yet to be made public using a wide array of channels easily accessible to the citizens (website, papers and radio).	

Annex 7: Integrated Risk Assessment

<table>
<tr><td colspan="5">1. PROGRAM RISKS</td></tr>
<tr><td>2.1 Technical Risk</td><td colspan="4">Rating: Moderate</td></tr>
<tr><td rowspan="2">Description:

• Overall weak institutional capacity in the public sector, particularly at LGAs (CHMTs), particularly in the context of increased autonomy of health facilities in implementing service delivery improvements.</td><td colspan="4">Risk Management: Project preparation would identify all required technical assistance and work with government to incorporate into the budget framework. Mobilize other financiers/donors to ensure complementary financing for technical assistance.</td></tr>
<tr><td>Resp: Government and Bank</td><td>Stage: Preparation and Implementation</td><td>Due Date : Continuous</td><td>Status: Ongoing</td></tr>
<tr><td rowspan="2">• Insufficient and delayed resources to finance required technical assistance to support program implementation.</td><td colspan="4">Risk Management: Bank mobilized other financiers/donors to ensure complementary financing for technical assistance.</td></tr>
<tr><td>Resp: Government and Bank</td><td>Stage: Preparation and Implementation</td><td>Due Date : Continuous</td><td>Status: Ongoing</td></tr>
<tr><td rowspan="2">• Moderate capacity of the Regional level (RAS, RHMT) to oversee, support and monitor LGAs to ensure adherence to national policies and quality of health services.</td><td colspan="4">Risk Management: PMORALG has established a Health Services Working Group at the central level that will soon be upgraded to a ministerial department. This will increase technical capacity for PMORALG to interpret sector policies and support capacity building and supervision of regional teams and LGAs

At the regional level, PMORALG plans to restructure the Regional Health Management Team to create two team – a smaller management team and a larger technical team. The technical team will have all technical experts needed at the regional level to provide technical support and ensure provision of quality health services in all LGA.

PMORALG at Regional level will create multidisciplinary teams from public, NGO, faith based and private entities that will undertake verification of results at health facility level reported through the routine HMIS. The verification will be used for payment of RBF incentives to health facilities and Health basket fund performance grants to LGA.</td></tr>
<tr><td>Resp: Government</td><td>Stage: Preparation and Implementation</td><td>Due Date : Continuous</td><td>Status: Ongoing</td></tr>
<tr><td>2.2 Fiduciary Risk</td><td colspan="4">Rating: Substantial</td></tr>
<tr><td>Description:

Financial Management (FM)</td><td colspan="4">Risk Management: Program will support capacity building of fiduciary staff covering areas where deficiencies were identified (reporting, PPA 2011 and its Regulations, contract management, etc.).</td></tr>
</table>

• Weak FM arrangements at the lower level and absence of fiduciary systems and guidelines at the hospitals, dispensaries and health centers. • FM systems in the HCFs, once put in place, will be manual and not be connected to the Integrated Financial Management Information System. • Delayed release of funds as well as weak internal control environment as a result of weak internal audit function. ***Procurement*** • Inadequate staffing in LGAs. • Inadequate knowledge of PPA 2011 and its Regulations, planning, bidding documents & request for proposals preparation and evaluation of bids/proposals. • Weak contract management, record keeping and management system. • Inefficient management of procurement processes, including delays in vetting contracts above TZS 50,000,000 by the Attorney General, and in awarding contracts pending finance committee decision. • Risks of receiving frivolous complaints during cool-off period of 14 days as there is no monetary value attached to ensure only genuine complaints are lodged;	**Resp:** Government and Bank	**Stage:** Implementation	**Due Date :** Continuous	**Status:** Ongoing
	Risk Management: Sound records management system to be implemented in all LGAs and participating MDAs.			
	Resp: Government	**Stage:** Implementation	**Due Date :** Continuous	**Status:** Ongoing
	Risk Management: POM to detail FM reporting formats, and timelines and responsible parties for each stage of the procurement cycle			
	Resp: Government	**Stage:** Preparation and Implementation	**Due Date :** Continuous	**Status:** Ongoing
	Risk Management: Qualified and experience staff/consultants will be recruited to support Program, including Account Technicians to support HCFs.			
	Resp: Government	**Stage:** Implementation	**Due Date :** Continuous	**Status:** Ongoing
2.3 Environmental and Social Risk	**Rating:**	**Moderate**		
Description: • Insufficient institutional and technical capacity in BRNH to handle environmental and social management issues. • Weak inter-institutional and coordination between the various related agencies. • Annual Performance Audit does not include the requirement or the technical expertise to assess performance of the ESSA. • Lack of formalized and effective complaint mechanism to address social and environmental issues. • Mixed formal Social Accountability mechanisms at various levels.	**Risk Management:** Program includes resources (manpower and financial) for implementation of environmental and social due diligence measures.			
	Resp: Government and Bank	**Stage:** Implementation	**Due Date:** Continuous	**Status:** Ongoing
	Risk Management: Program includes activities for capacity building on environment and social management as well as incentives for health care waste management (under the RBF) and social accountability, as detailed in the operational manual and monitored as part of the Results Framework and Monitoring of the project.			
	Resp: Government	**Stage:** Implementation	**Due Date:** Continuous	**Status:** Ongoing
2.4 Disbursement linked indicator risks	**Rating:**	**Moderate**		

Description: Government will either not allocate required resources to attain DLIs or delay the release of funds.	**Risk Management:** Operation design includes specific DLIs to encourage adequate and timely allocation of budget.			
	Resp: Government and Bank	**Stage:** Preparation and Implementation	**Due Date:** Continuous	**Status:** Ongoing
Description: Poorly defined or improperly measured DLIs may lead to problems with their reporting and data inaccuracy.	**Risk Management:** • Careful choice of DLIs to ensure that they are measurable and verifiable Development of detailed and clear protocols for the measurement of DLIs as part of POM			
	Resp: Government and DPs	**Stage:** Preparation and Implementation	**Due Date:** Continuous	**Status:** Ongoing
2.5 Other Risks (Optional)	**Rating:** **Moderate**			
Description: Incoming administration (November 2015) may feel less ownership toward Program.	**Risk Management:** BRN includes on-going broad based consultation at all levels to generate support for the program.			
	Resp: Government	**Stage:** Preparation and Implementation	**Due Date:** Continuous	**Status:** Ongoing
Description: There is an inherent risk of over-reporting of results as achievement of the results trigger disbursements.	**Risk Management:** Detailed protocols to monitor and verify performance indicators would be agreed upon during preparation. Independent third party will be used for the measurement or audits of selected DLI where appropriate			
	Resp: Government and Bank	**Stage:** Preparation and Implementation	**Due Date:** Continuous	**Status:** Ongoing
OVERALL RISK RATING	**Substantial**			

Annex 8: Program Action Plan

Action Description	DLI	Covenant	Due Date	Responsible Party	Completion Measurement
Technical					
Appoint Internal Auditor General as the independent verification entity			Within 3 months from Effectiveness Date	MOHSW MOF	- Verification entity formally appointed - TOR acceptable to the World Bank
Submit the basic reporting requirements for the sector as per the HBF requirement			Each basic reporting requirement has its specific due day as per the HBF schedule	MOHSW, PMORALG	- Each report is formally adopted by due date, with comments by stakeholders taken into account
Environmental and Social					
Implement the ESSA through the following: i) Inclusion of HCWM in the CCHP ii) Monitoring and Reporting on the implementation of the HCWM activities in the CCHP			As per SWAp reporting requirements and schedule	MOHSW	CCHP Plan and Implementation summary reports
Fiduciary					
Review the existing procurement vetting mechanisms with a view to reducing backlog			First year of implementation	MOHSW, PMO-RALG and MOF	Formal recommendations on the procurement vetting process jointly sent by MOF, PMO-RALG and MOF to AG
Operationalize the MSD system that issues out of stock notices to facilities within one day as prescribed in the 2013 Public Procurement Regulation Act (Section 140) and the 2013 Public Procurement sub-Regulations (Subsections 1 to 6)			First 12 months of implementation	MoHSW, MSD	System in place and stock out notices are issues in 1 day.

Conduct annual independent procurement audits of the program as well as value for money (VFM) audits by PPRA and CAG.		Y	(i) procurement audits-After year 1 of implementation and thereafter annually, and (ii) VFM audit Midterm and end of program	MoHSW, PMORALG	Procurement and VFM audit reports.

Annex 9: Implementation Support Plan

1. The proposed implementation plan is consistent with the Program-for-Results operational guidelines. Program implementation rests under the responsibility of MOHSW and PMORALG, with targeted and continuous implementation support and technical advice from the World Bank and development partners. The Bank's implementation support will broadly consist of:

- Capacity building activities to strengthen the national and local levels' ability to implement the program, covering the technical, fiduciary, and social and environmental dimensions.
- Provision of technical advice and implementation support geared to the attainment of the program's Development Objectives (PDO).
- On-going monitoring of implementation progress, including regularly reviewing key outcome and intermediate indicators, and identification of bottlenecks.
- Review and verification of DLI protocols, complemented by random technical audits.
- Monitoring risks and identification of corresponding mitigation measures.
- Impact evaluation activities.
- Close coordination with other donors and development partners to leverage resources, ensure coordination of efforts, and avoid duplication.

6. Further, implementation support will include the provision of capacity strengthening in procurement, financial management and governance and anti-corruption. An annual fiduciary review will be conducted for the program supported by mainly the Internal Audit Department and PPRA. Adequate budget will need to be allocated for this review. This review will be supplemented by on-site visits done by the Bank's fiduciary staff at least twice a year. Reliance will also be placed on the annual audit reports produced by the Controller and Auditor General. In addition, desk reviews will be done for audit, financial, procurement and any other reports received during the financial year. In-depth reviews may also be commissioned by the Bank whenever deemed necessary.

Main focus of Implementation Support (template)

Time	***Focus***	***Skills Needed***	***Resource Estimate***	***Partner Role***
First twelve months	Institutional capacity enhancement at the national to strengthen country systems. Technical advice to support Program implementation.	Technical, fiduciary, environment, and social	3 implementation support visits by technical specialists focused on capacity building, technical assistance and monitoring. 2 implementation support visit by fiduciary specialists	

			focused on capacity building. 1 implementation support visit by environment and social specialists focused on capacity building and reviewing/strengthening effectiveness of redress mechanism.	
12-24 months	Institutional capacity enhancement at the local levels to strengthen implementation capacity. Implementation monitoring. Technical advice to support program implementation.	Technical (including M&E), fiduciary, environment, and social	2 implementation support visits by technical and fiduciary specialists focused fiduciary support and implementation support. 1 implementation support visit by social and environmental specialists focused on strengthening local capacity and implementation support.	
Implementation Mid-term	Implementation progress review and identification of necessary mid-course adjustments.	Technical (including M&E), fiduciary, environment, social, and operational	1 implementation support visit including technical, fiduciary, social, environment, M&E and operational specialists.	
24-48 months	Implementation monitoring and evaluation. Technical advice to support program implementation.	Technical (including M&E), and fiduciary		

Task Team Skills Mix Requirements for Implementation Support (template)

Skills Needed	Number of Staff Weeks	Number of Trips	Comments
Project Management (TTL)	10	2	HQ based
RBF Specialist	4	2	HQ based
Technical Specialists	16	3	International/Country based
M&E Specialist	4	1	International
FM Specialist	4	2	Region-based
Procurement Specialist	4	1	Region-based
Environmental Specialist	2	1	HQ-based
Social Specialist	2	1	Country-based
Administrative Support	6	0	Country-based