PROGRAM-FOR-RESULTS INFORMATION DOCUMENT (PID)
CONCEPT STAGE

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Program Name	Big Results Now for Health
Region	Africa
Country	The United Republic of Tanzania
Sector	Health, Nutrition & Population
Lending Instrument	Program for Results (PforR)
Program ID	P152736
Borrower(s)	Ministry of Finance
Implementing Agency	Ministry of Health and Social Affairs; Prime Minister's Office, Regional Administration and Local Government
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Concept Review Decision	
Other Decision *{Optional}*	

I. Introduction and Context

A. Country Context

1. Tanzania's GDP growth has remained stable at around 7 percent over a decade thanks to increased private consumption and public investment together with rapidly expanding sectors such as communication, construction, financial services, and mining. Inflation declined to 5.9 percent in October 2014, down from over 19 percent at the end-2011, due to tight monetary policy and falling international energy and food prices. However, fiscal space has been reduced during the past four years as result of combination of lower-than-expected domestic revenue collection, diminishing aid disbursements, and higher investment in infrastructure projects.

2. Poverty has reduced marginally to around 28 percent in 2012, down from 34 percent in 2007, notwithstanding strong and stable economic growth. However, 44 percent of the population live on less than US$ 1.25 per day and 90 percent of the population live on less than US$ 3 per day. The improved but still low elasticity of growth on poverty reduction is explained by a lagging impact of improvements in the human capital stock on income generation opportunities and by the lack of growth in labor intensive sectors, including agriculture in rural areas where 84 percent of poor households are located based on the 2011/12 Household Budget Survey (HBS). The limited productivity gains in the manufacturing and agriculture sectors explain limited progress on poverty reduction. Moreover, the recent Poverty Assessment by the World Bank using 2011/12 HBS shows that larger families, lower education and low access to infrastructure is associated with relatively high poverty rate in Tanzania. Nonetheless, poverty

has become more responsive to growth and inequality has declined in Tanzania.[1]

B. Sectoral and Institutional Context of the Program

3. Tanzania has made significant strides in improving immunization coverage and surpassing the Millennium Development Goals 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). However, the progress in reduction of maternal mortality and neonatal mortality has been slow. Maternal mortality ratio remains high at 454 deaths per 100,000 live births in 2010 against a backdrop of low facility deliveries and family planning coverage while neonatal mortality rates are 26 per 1,000 live births (TDHS, 2010). There is also a persistent high level of stunting (42 percent among children under five years of age), affecting over 3 million children.

4. 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 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.

Table 1: Tanzania's health outcomes and health expenditures

	Tanzania[1]		**Sub-Saharan Africa[2]**
Outcome Indicators	**2005**	**2010**	**20133**
Under 5 Mortality Rate per 1,000 births	112	81	92.4
Infant mortality rate per 1,000 births	68	51	61.1
Maternal mortality ratio per 100,000 live births	578	454	510
Total Fertility Rate (Children per Woman)	5.7	5.4	5.1
Stunting, Height for Age (<-2SD) %	38	42	37.4
Underweight, Low Weight for Age (<-2SD) %	22	16	21
Wasting, Weight for Height (<-2SD)	3	5	9
Service coverage indicators			
Skilled birth attendance %	47	51	49.7
Contraceptive prevalence rate (% of women ages 15-49)	20	27	24.3
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

[1] The Gini coefficient (of consumption per capita) declined from 0.39 in 2007 to 0.36 in 2011/12.

[2] Masanja, H., et al, *Child survival gains in Tanzania: analysis of data from demographic and health surveys*, The Lancet, 2008; 371: 1276–83.

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]All health financing indicators listed under "2010" indicate 2012 data as the latest;
[4]All per capita expenditure data are in the unit of current US$ (i.e. at exchange rate rather than PPP).
Source: DHS, World Development Indicators,and WHO data.

5. In Tanzania, access to a 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 an high fertility environment. What is of concerns is the provision of quality obstetric care (basic and comprehensive). Although women give birth in most facilities, a mere 7.5 percent of those health facilities can be deemed compliant with the offering of BEmOC. Only a dismal 2.6 percent of dispensaries offer the full BEmOC package. This proportion increases only to 18 percent for health centers and a paltry 44 percent for first level hospitals (Service Delivery Indicators, 2014).

6. On the supply side, a range of serious health system challenges account for such poor health outcomes:

- First, while health financing is highly dependent on external support (which accounted for 48 percent of total public expenditure on health in 2011/12), such support is fragmented with a significant share being off-budget. Development partners have not been able to leverage government's health budget for results, resulting in a displacement effect. Public expenditure on heath has been flat in real terms, while the share of health in the Government's budget has been declining from 11.9 percent in 2010/11 to 8.7 percent in 2013/14. In addition to inadequate government's budget allocation for health, government's budget execution is poor with late release.

- Second, human resource for health (HRH) is a major constraint to service delivery. Nation-wide, there are 554 dispensaries without skilled health workers. 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).

- Third, 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 serve as a major bottleneck preventing resources to reach lower levels.

- Fourth, there is a poor accountability for results at all levels, especially between (i) central government and Local Government Authorities (LGA), (ii) LGA and facilities and (iii) facilities and communities. More than half of health workers are either absent or late during work hours. Quality of care is low with poor adherence to good clinical practices, frequent stock-out of essential drugs and consumables and poor facility physical condition. All of this significantly compromise patient care.

- Finally, the progress in engaging private health sector through Public Private Partnerships has been very slow.

7. The Mid-term Review (MTR) for the ongoing Health Sector Strategic Plan (HSSP) III concluded that the health sector is making progress in all strategic areas, but the overall pace is slower than anticipated, with more progress in systems development (policies, strategies, guidelines, work plans, etc.) than in improving service delivery. [3] Innovations are only slowly trickling down to front line health facilities. Disease control programs are performing better than either general or reproductive health services, and attendance rates of outpatient departments and maternal health clearly show that the population is not satisfied with the services provided. The MTR suggested that the focus for the remaining HSSP III period and going forward should be on (i) improving value for money by making optimal use of available resources; and (ii) increase transparency and accountability by showing results and engaging the community in strengthening the health services and improving quality. In sum, the need is for greater emphasis on outcomes in combination with sustainable service delivery systems; harmonization of processes is not an end in itself.

8. To intensify the response to health system challenges as identified in the MTR, the Government has recently embarked on a major endeavor, with two high profile initiatives: Big Results Now in Health (BRN in Health) and Results-based Financing (RBF). Both are embedded in the medium-term Health Sector Strategic Plan (HSSP) which guides health sector development in Tanzania and is updated every five years.

C. Relationship to CAS/CPS

9. The Tanzania Country Assistance Strategy (CAS) FY2012-15[4] is aligned with the priorities set at the Government's National Strategy for Growth and Poverty reduction (MKUKUTA II 2010/11 – 2014/15) and the World Bank's Africa Strategy (2011). The MKUKUTA II focuses on three clusters: (i) growth and reduction of income poverty; (ii) improvement of quality of life and social well-being; and (iii) good governance and accountability. Explicitly, it identifies as priority areas human resources for health, maternal health, and improvement in health facilities and service delivery. Consistent with the 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,

[3] 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.
[4] The June 2014 CAS Progress Report proposed a 12 month extension to the CAS, until 2016.

maternal mortality, etc.). Governance and public sector capacity is a foundation of the Africa Strategy.

10. The proposed operation is fully aligned with two of the four objectives set out in the CAS: (i) *strengthened human capital and safety nets*, which has as one of its outcomes to improve access to and quality of health care delivery; and (ii) *promote accountability and governance*, a cross-cutting objective which aims 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, highlighting very high maternal mortality rates as one of the critical issues 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.

11. The June 2014 CAS Progress Report (80313-TZ) restates the relevance of the CAS, but includes adjustments to reflect recent developments in Tanzania and the government's evolving priorities, and to align with the World Bank Group goals of ending poverty and boosting shared prosperity**.** Such adjustments are organized around two clusters, the second one – programs that target reduction of extreme poverty and improvements in quality of social services – under which the proposed operation falls. Further, the Progress Report proposes using performance based instruments such as the PforR to focus on delivery and results.

12. The proposed Program is consistent with the CAS FY12 – FY15 and its Progress Report, both in terms of priority areas and engagement approach. The overall objective of the Program is to improve the utilization and quality of primary health care services, with a special focus on maternal and neonatal child health. Further, by adopting a performance-based financing mechanism, the operation seeks to promote public service performance management and responsiveness, accountability and good governance.

II. Program Development Objective(s)

A. Program Development Objective(s)

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

B. Key Program Results

i. Percentage of PHC facilities with 1- and 2-Star ratings at baseline achieving 3-Star and above by year 3
ii. Number of women receiving at least 2 doses of intermittent preventive treatment for malaria as part of antenatal visits during their last pregnancy
iii. Number of institutional deliveries
iv. Number of women receiving post-natal care within 7 days after delivery
v. BRN Regions with critical HRH shortage reaching the national averages for the ratios of clinicians and nurses per 10,000 population

III. Program Description

14. The Government of Tanzania's program in health as being defined in its Health Sector Strategic Plan has two complementary elements: (i) Big Results Now in Health (BRN in Health) and (ii) Results-based Financing Initiative.

Big Results Now in Health

15. 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 work streams as follows:

(i) *Performance Management*: This work stream has various elements. All PHC facilities in the country will first undergo a "Star Rating" assessment, which is in essence a stepwise accreditation scheme. On the basis of baseline assessment, a facility improvement program will be implemented nation-wide to help facilities improve their performances and star ratings. In addition, measures such as fiscal decentralization at the facility level, performance targets and contracts for personnel, as well as social accountability mechanisms will be prioritized.

(ii) *Human Resources for Health*: This work stream includes a set of interventions to improve the distribution of skilled health workers, especially the 7 cadres of clinicians (medical doctors and allied health practitioners) and nurses (including midwives) at the PHC level in nine regions with lower than national average human resources in the above cadres.

(iii) *Health Commodities*: This work stream tackles key issues along the health commodities supply chain - finance and business model, procurement and distribution, inventory management as well as governance.

(iv) *Mother and Neonatal Child Health*: This work stream focuses on measures to improve both coverage and quality of MNCH along the continuum of care, which includes (a) ensuring dispensaries and health centers meet Basic Emergency Obstetric and Neonatal Care (BEmONC) requirements, (b) expanding Comprehensive Emergency Obstetric and Neonatal Care (CEmONC) to selected hospitals and health centers, (d) strengthening the corresponding satellite blood banks which serve facilities with CEmONC, and (e) extending MNCH services to communities through the use of community health workers and awareness campaigns. Five regions that are poorly performing on maternal and neonatal mortality indicators were selected for priority focus.

Results-based Financing Initiative

16. In addition to BRN for Health, the GOT has a Results-based Financing Initiative (RBF) for PHC facilities. Initially referred to as "Pay for Performance", this nationwide program was initiated in 2008. The original design has some conflict of interest issues between providers and verifiers. The Government of Norway was therefore requested to support a pilot with improved design in the Pwani region. An independent impact evaluation of the Pwani pilot (conducted between 2011 and 2013) showed promising results, with significant positive effects on a range of

incentivized services as follows:

- Any antenatal care (ANC) visit – increase of three percentage points;
- Being prescribed malaria medication during ANC – increase of 7 percentage points;
- Receiving 2+ doses for malaria during ANC – increase of 11 percentage points;
- Facility based deliveries – increase of 8 percentage points;
- Public facility deliveries – increase of 6 percentage points; and
- Immunizing newborns with polio vaccine – increase of 6 percentage points.

The evaluation also suggested further modifications in design to include system strengthening measures and therefore broaden the scope of the program beyond maternal and child health.

17. Based on such recommendations, the Pay for Performance program has been redesigned and transformed into a "Results Based Financing Initiative". Planned to be rolled out in a phased manner, the program aims to enhance provider accountability for results and encompasses broader health system strengthening measures through incentivizing multiple levels of the health system for both quality and quantity of PHC services at dispensaries, health centers and district hospitals. Phase 1 of the RBF roll-out will cover at least 7 regions by 2019.

What will the PforR support?

18. The PforR will support a subset of the above Government program. This includes three (out of four[5]) BRN in Health work streams (Performance Management, HRH and MNCH) and Phase 1 of the RBF Program.

19. The three work streams of BRN in Health and RBF are complementary. While BRN in Health work streams aim to get short to medium-term results, RBF helps to institutionalize these gains and ensure long-term, sustainable results on a continuous basis.

A summary of the Government program vs. the Program supported by the PforR operation

The Government program			The Program supported by PforR operation
Initiative	*Sub-Initiative*	*Regions (and share of total population)*	
BRN in Health	*Performance*		
	+ Stepwise Accreditation	All regions (100%)	x
	+ Facility Quality Improvement	All regions (100%)	x
	+ Fiscal decentralization	All regions (100%)	x
	+ Social accountability	All regions (100%)	x
	Health Commodities	All regions (100%)	
	HRH Distribution	9 regions (35%)	x
	Obstetric and Neonatal Care	5 regions (25%)	x
RBF Program (First Phase)		5 BRN-MNCH regions plus Pwani and Shinyanga (29%)	x

[5]The health commodities work steam is likely to receive significant support from USAID and DANIDA and therefore will not be included in the Program.

IV. Initial Environmental and Social Screening

20. Potential adverse environmental effects of the Program are likely to be due to the generation of health care wastes at PHC levels which are not managed properly. Under the Program, there are no new investments that might involve construction of new and/or large renovation of medical facilities. Overall, the quality of policies and regulations related to health care waste management is acceptable in Tanzania. It is the implementation of such policies and regulations that remains weak. However, various activities in the Program (e.g. "Star rating" stepwise accreditation of facilities, RBF) are expected to improve implementation of health care waste management at the PHC level. No major untoward social consequences are expected of the Program.

21. An Environmental and Social Systems Assessment (ESSA) will be carried out as part of project preparation. This would include an assessment of: (a) existing regulations and policies; (b) institutional capacity; and (c) effectiveness of implementation and demonstrated record. It is expected the ESSA will result in an action plan to strengthen institutional capacity to minimize identified environmental and social risks. The ESSA report will be publicly available and consulted before project appraisal.

V. Tentative financing

Source:	($m.)
Borrower/Recipient	
IBRD	
IDA	100 million
Others (GFF)	15 million
Total	115 million

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