

THE UNITED REPUBLIC OF TANZANIA

**PROGRAM FOR RESULTS
STRENGTHENING PRIMARY HEALTH CARE FOR
RESULTS**

**ENVIRONMENT AND SOCIAL SYSTEMS ASSESSMENT
(ESSA)**

Prepared by the World Bank

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ACRONYMS AND ABBREVIATIONS

BEmONC	Basic Emergency Obstetric and Neonatal Care
BRNH	Big Results Now in Health
CAS	Country Assistance Strategy
CCHPs	Comprehensive Council Health Plans
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CSO	Civil Society Organization
DED	District Executive Director
DLIs	Disbursement-linked Indicators
EMA	Environment Management Act
GAC	Governance and Anti-corruption
GDP	Gross Domestic Progress
GFF	Global Financing Facility
GoT	Government of Tanzania
GPSA	Government Procurement Services Agency
HBF	Health Basket Fund
HBS	Household Budget Survey
HEPRU	Health Emergency Preparedness Unit
HRH	Human Resource for Health
HSSP	Health Sector Strategic Plan
LGAs	Local Government Authorities
MKUKUTA	Government National Strategy for Growth and Poverty Reduction
MMAM	Mpango wa Maendeleo wa Afya ya Msingi (PHSDP)
MNCH	Maternal, Neonatal Child Health
MOF	Ministry of Finance
MOHSW	Ministry of Health and Social Welfare
NEMC	National Environment Council
OPD	Outpatient Department
PfoR	Program for Results
PHC	Primary Health Care
PHSDP	Primary Health Services Development Programme
PMTCT	Prevention of Material to Child Transmission of HIV Virus
PMO-RALG	Prime Minister's Office – Regional Administration and Local Governance
RBF	Results-based Financing
RHMT	Regional Health Management Team
TDHS	Tanzania Demographic Health Survey
VPO-Envt	Vice-President's Office – Environment

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EXECUTIVE SUMMARY

The Program for Results (PforR) operation - *Strengthening Primary Health Care for Results* – is designed to support the Government of Tanzania’s primary health care (PHC) program (2015/16 – 2019/20), with a strong focus on a key government initiative – Big Results Now in Health (BRNH). The PforR approach innovatively links the disbursement of funds directly to the delivery of defined results and builds on increased reliance on borrower safeguard and oversight systems. The Program Development Objective of the operation is to improve the quality of primary health care (PHC) with a focus on maternal, neonatal and child health (MNCH) services in Tanzania. The total funding allocated under this PforR operation is US\$270 million, representing 10.1% of the total Program cost and will support the Government's program. Like all other Health programs in Tanzania, the Program will be implemented by the Ministry of Health and Social Welfare and the Prime Minister’s Office- Regional Administration and Local Government (PMO-RALG).

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*. This report presents the findings of the ESSA exercise and its recommendations.

The ESSA process included extensive stakeholder consultations and disclosure of the draft ESSA report following the guidelines of the World Bank’s Access to Information Policy. The ESSA consultation process and content are embedded in the Program consultation process.

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 a significantly adverse environmental or social footprint, if construction activities and healthcare facility operations are well managed. Impacts are also expected to be moderate since the infrastructural 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 systems for sanitation and water supply and 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, and there will not be any land acquisition.

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.

The ESSA analysis presented here 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 identified the following main areas for action in order to ensure that the Program interventions are aligned with the Core Principle 1, 3 and 5 of OP/BP 9.00 applicable to the Program: namely Health Care Waste Management and Social Accountability. The gaps identified through the ESSA and subsequent actions to fill those gaps are expected to directly contribute to the Program’s anticipated results for enhancing quality of primary health care (PHC) services nation-wide with a focus on maternal, neonatal and child health (MNCH) services.

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*), 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*). Details on the Disbursement –Linked Indicators and their sub- indicators are in Annex III. The key measures are defined in Table 1 below:

Table 1: Measures to Strengthen System Performance for Environmental and Social Management

Objective	Strengths and Weaknesses	Measures
Defining the System for Environmental and Social Management	<p><u>Strengths:</u> Adequate national regulatory framework and technical guidelines for environmental and social due diligence with respect to the Program.</p> <p>Existence of environmental and social practices and procedures under existing World Bank funded health program.</p> <p><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</p>	<p>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.</p> <p>The Program 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</p>

	<p>as compared to Core Principles of OP/BP 9.00. The requirements for management and use of asbestos need enhancement.</p> <p>Participatory Planning, implementation and monitoring is weak due to capacity related constraints including incentives.</p> <p>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.</p> <p>Application of the social accountability (SAc) mechanisms and other participatory tools are isolated and performance on key aspects is dismal.</p> <p>There is low awareness of Council vs Health facility committees' roles and responsibilities including their expected collaboration.</p>	<p>with OP/BP 9.00 principles but more focus is needed on implementation procedures and institutional mechanisms. The process for grievance redress and complaint handling, and inclusive and participatory consultations and feedback for social accountability also needs improvement.</p> <p>The Program will require increased coordination among various ministries, agencies and development partners on environmental and social aspects to further support implementation. The process and criteria for monitoring, enforcement and reporting on environmental and social measures will be part of overall Program reporting and data management.</p> <p>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).</p> <p>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.</p>
<p>Technical Guidance and Implementation Capacity</p>	<p><u>Strengths:</u></p> <p>Technical guidelines and standards for Health Care Waste Management exist.</p> <p>The ESMF, which has been assimilated within the Government systems identifies construction related impacts and includes well-defined mitigation measures to be implemented during construction.</p> <p>Guidelines for the constitution of Health Facility Governing Committees (HFGC) with stakeholders' representation exist.</p> <p>Guidelines and training program for social accountability mechanisms that include grievance mechanisms exist.</p> <p><u>Weaknesses:</u></p> <p>HCWG guidelines and standards have not been systematically implemented.</p> <p>Weak intersectoral coordination around environmental and social issues.</p> <p>Functionality of the HFGCs is limited due to capacity constraints.</p> <p>Social Accountability (SAc) efforts have limited coverage.</p> <p>Implementation of SAc guidelines is limited due to capacity constraints.</p> <p>Participatory Planning, implementation and monitoring is weak.</p>	<p>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. The ESMF identifies construction related impacts and includes well-defined mitigation measures to be implemented during construction; these requirements will be included in the Program Operations Manual.</p> <p>Follow up on the implementation of the HCWM and Community Engagement Plans will be a part of World Bank supervision.</p>
<p>Addressing Capacity Constraints</p>	<p><u>Weaknesses:</u></p> <p>The Healthcare Waste Management Program is severely under-resourced (manpower and funds) which prevents it from providing satisfactory oversight.</p> <p>There is <i>limited capacity and awareness</i> of environmental health risks associated with poor</p>	<p>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.</p> <p>Capacity building for environmental and social actions</p>

	<p>quality of water, <i>inadequate sanitation and hygiene</i>, which prevents adequate attention be paid to these issues.</p> <p>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.</p>	<p>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.</p> <p>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.</p>
<p>Improved systems for Information Disclosure and Stakeholder Consultation</p>	<p><u>Strengths:</u> 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.</p> <p><u>Weaknesses:</u> 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 <i>mechanism for handling grievances</i>, 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 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).</p>	<p>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 increased 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.</p> <p>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.</p>

SECTION I

Introduction

1. The Government of Tanzania's primary health care program is being proposed for financing through the World Bank's Program-for-Results (PforR) financing instrument. The PforR, entitled *Tanzania: Strengthening Primary Health Care for Results*, innovatively links the disbursement of funds directly to the delivery of defined results. The instrument builds on increased reliance on borrower safeguard and oversight systems.

2. The Program Development Objective (PDO) of the proposed PforR operation is to improve quality of primary healthcare (PHC) services nationwide with a focus on maternal and neonatal child health (MNCH) services. This objective is fully aligned with the key priorities and specific objectives of the BRN in Health program which is defined in the Tanzania Health Sector Strategic Plan and developed as part of the Tanzania's Development Vision 2025. The requested PforR support, which amounts to US\$ 270 million is aligned to the entire Big Results Now in Health (BRN in Health) program of expenditures.

3. To inform the preparation of the PforR operation the World Bank has conducted an Environmental and Social Management System Assessment (ESSA) of Tanzania's existing environmental and social management system reflected in the national legal, regulatory, and institutional framework that will be used to address environmental and social effects of the activities financed by the PforR operation. The ESSA defines measures to strengthen the system, and proposes to integrate those measures into the overall PforR operation. This report presents the findings of the ESSA exercise. The ESSA was undertaken to ensure consistency with six Core Principles outlined in the guidelines to the World Bank's OP/BP 9.00 Program-for-Results Financing in order to effectively manage Program risks and promote sustainable development.

4. The six Core Principles are:

1. Promote environmental and social sustainability in the Program design; avoid, minimize, or mitigate adverse impacts, and promote informed decision-making relating to the Program's environmental and social impacts.
2. Avoid, minimize, or mitigate adverse impacts on natural habitats and physical cultural resources resulting from the Program.
3. Protect public and worker safety against the potential risks associated with: (i) construction and/or operations of facilities or other operational practices under the Program; (ii) exposure to toxic chemicals, hazardous wastes, and other dangerous materials under the Program; and (iii) reconstruction or rehabilitation of infrastructure located in areas prone to natural hazards.
4. Manage land acquisition and loss of access to natural resources in a way that avoids or minimizes displacement, and assist the affected people in improving, or at the minimum restoring, their livelihoods and living standards.
5. Give due consideration to the cultural appropriateness of, and equitable access to, Program benefits, giving special attention to the rights and interests of the Indigenous Peoples and to the needs or concerns of vulnerable groups.

6. Avoid exacerbating social conflict, especially in fragile states, post-conflict areas, or areas subject to territorial disputes.

5. The ESSA analyzed the environmental and social management system for the Program to assess applicability for each of the Core Principles and ensure consistency with those that apply. The gaps identified through the ESSA and actions recommended to fill those gaps are expected to directly contribute to the Program's anticipated results in the Health sector. This Report presents an analysis of the existing system vis-à-vis the relevant Core Principles for environmental and social management in the guidelines to OP/BP 9.00, and presents an Action Plan that will be incorporated into the overall program.

SECTION II Background

2.1 Country Profile

6. 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.

7. The population of Tanzania is estimated to be about 40 million people with about 3% growth rate. Tanzania has sustained robust economic growth of around 7 percent per year since 2000, becoming one of the best performers in Sub-Saharan Africa (SSA). Poverty has however reduced marginally to around 28 percent in 2012, down from 34 percent in 2007. Further, 44 percent of the population lives 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.

8. Agriculture is the primary economic activity for 80% of the population living in the rural areas. The severe degradation of land, forests and water resources that support agriculture has become an obstacle to the revival of the rural economy. Life expectancy at birth is 47 years (decline due to AIDS) compared to 50 years average in SSA, and infant mortality of 85 per 1000 live births compared to 92 for SSA. Water and sanitation services are deficient, with access to improved water source estimated to be about 49% of population. Communicable diseases (HIV/AIDS, persistent malaria, ARI and diarrhea), malnutrition and poor quality health care have been major factors in poor survival indicators.

9. For the purposes of the ESSA, the groups identified as most vulnerable in the Tanzania Participatory Poverty Assessment are: children, persons with disabilities, youths (unemployed, females, youths with unreliable incomes), people living with long illnesses (e.g. HIV/AIDS), women (widows and those not able to support themselves), drug addicts and alcoholics. While there is little data on these specific groups, the experience with Project Affected People in similar projects found that a high proportion of PAPs (with respect to resettlement) had at least one vulnerable member in their household.

10. A 2012 review of the Tanzania Development Vision 2025 led to the candid recognition by the Government that the implementation of programs and reforms was slow in key sectors. This compelled the authorities to adopt Big Results Now (BRN) program which oversees and monitors the implementation of programs in order to accelerate the delivery of results in six key sectors; namely energy and natural gas, agriculture, water, Health, transport and the mobilization of resources. The BRN is managed by the Presidency under the President's Delivery Bureau and is supported by several development partners including the World Bank, USAID, Swedish International Development Agency, DFID, and the Bill and Melinda Gates Foundation. The first stage of the BRN program started in mid-2013 and it is expected to have achieved its main targets by 2015.

2.2 Health Sector in Tanzania

11. Tanzania has made significant strides in improving immunization coverage and surpassing the Millennium Development Goal (MDG) 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.¹ 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.

12. A large proportion of child survival gains in Tanzania has been attributed to investments in health systems and scaling up of specific interventions through decentralization. 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 levels².

13. In Tanzania, access to a health care has sharply improved in recent years with more people being within two hours of a health facility. Moreover, three out of four (74.9 percent) facilities offer services for women to give birth, which is a critical need in a high fertility environment. What remains of concern 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 are compliant with the offering of Basic Emergency Obstetric and Neonatal Care (BEmOC). Only 2.6 percent of dispensaries offer the full BEmOC package. This proportion increases only to 18 percent for health centers and 44 percent for first level hospitals.³

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

¹ Tanzania Demographic 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

³ Service Delivery Indicators, 2014.

- 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 health 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.
- Human resources for health (HRH) is a major constraint to service delivery. Nationwide, there are 554 dispensaries without skilled health workers. Those dispensaries are staffed by medical attendants who are not qualified to manage patients. 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).
- 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 have a bank account. Funding for PHC is channeled to local government authorities (LGAs), which are major bottlenecks preventing resources in reaching lower levels.
- There is poor accountability for results at all levels, especially (i) between central government and LGAs, (ii) between LGAs 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 conditions. All those conditions significantly compromise patient care.
- Progress in engaging the private health sector through public-private partnerships has been very slow.

15. The Government's Mid-term Review (MTR) of its 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. 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.

16. To intensify the response to health system challenges as identified in the MTR, the Government has recently embarked on a major endeavor, with a high profile initiative: Big Results Now in Health (BRNH). It is embedded in the medium-term Health Sector Strategic Plan (HSSP), which guides health sector development in Tanzania and is updated every five years.

2.4 Health Sector Strategic Plan IV (HSSP IV)

17. In January 2013, the President of Tanzania launched the “Big Results Now in Health” (BRN in Health) program, under which the traditional approach to planning and budgeting has been replaced by a more rigorous process of identifying challenges, setting goals, prioritizing key activities based on evidence, developing specific intervention details and ‘3-foot plans’ for implementation, including budget requirements for the specific interventions, and operationalizing a strong monitoring process from the central to the local levels.

18. In the structure of the Tanzania health system, primary health care (PHC) is delivered at district level and below, involving district hospitals, health centers, dispensaries and community based health services under the management of Council Health Management Teams (CHMT). Over the next five years, PHC will be guided by the Fourth Health Sector Strategic Plan 2015-2020 (HSSP IV). PHC under HSSP IV (including BRN in Health) constitutes the Government’s program. The total cost of the Program is US\$ 2.67 billion or 55 percent of the GOT’s health sector budget over the next 5 years.

2.4.1 Big Results Now in Health

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 (NKRAAs) as follows:

- (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 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 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 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.

2.4.3 Development Partners

20. The World Bank has a long history of support to health in Tanzania, starting with the Health and Nutrition Project in the early 1990s with many other projects that followed in the 2000s and the current Tanzania Basic Health Services Project. Other key partners in the health sector and specifically in the Health Basket Fund (HBF) that will support the HSSP IV include Ireland, Canada, Denmark, and Switzerland as well as UNICEF and UNFPA. Others like USAID specifically support the public sector systems strengthening to promote the delivery, quality and use of services particularly for underserved populations and are co-financing the RBF program.

SECTION III Program Description

3.1 The Program for Results (PforR) operation - Strengthening Primary Health Care for Results

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

22. The proposed PforR operation is aimed at improving quality of health services by focusing on strengthened human capital and social safety nets and promoting accountability and governance. The scope also includes infrastructure upgrades for preparing physical health facilities to qualify for support under the RBF. Like all other Health programs, the PforR operation will be implemented by the Ministry of Health and Social Welfare and the Prime Minister's Office- Regional Administration and Local Government (PMO-RALG).

3.2 Program Development Objective and Key Results

3.2.1 Program Development Objective

23. 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.

3.2.2 Key Program Results

24. Key Program results indicators include:
- i. Percentage of PHC facilities with 1 3-Star and above⁴;
 - 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.

3.2.3 Disbursement-linked Indicators

25. **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

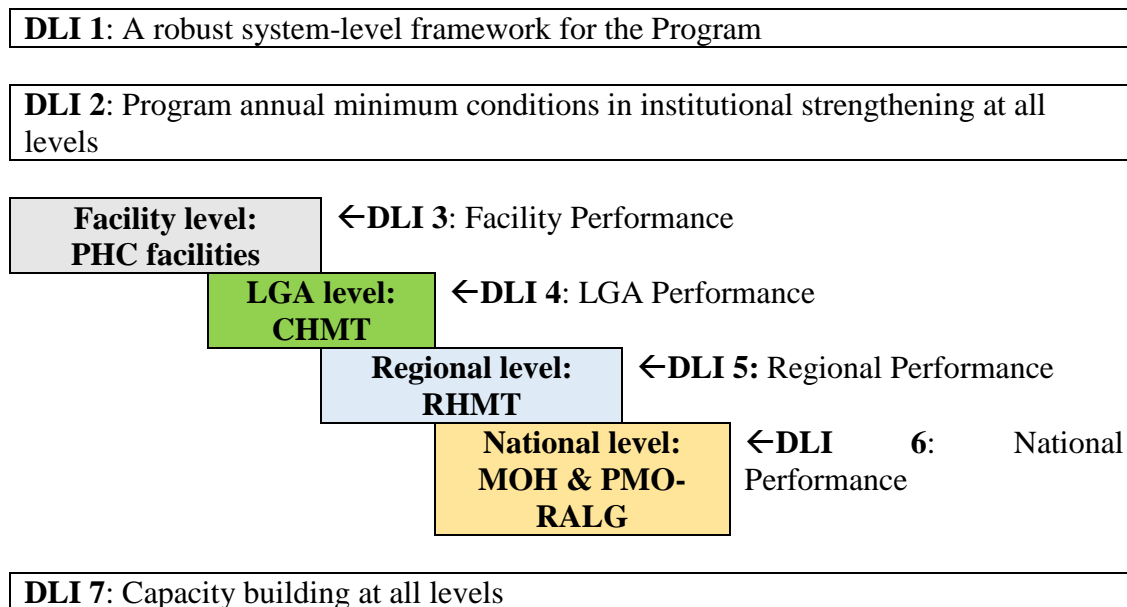
⁴ The "Star rating" accreditation scale is from 1 to 5 stars, with 5 being the best quality and 3 being the minimally accepted.

stakeholders to focus on critical results. The following principles were applied when selecting these DLIs:

- maximizing the use of existing indicators in the government’s program, especially those in HSSP IV and BRN;
- 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;
- stimulating performance at all levels of the system: national, regional, LGA and PHC facility;
- prioritizing the use of the government’s routine information system (e.g. DHIS2) and existing reporting mechanisms (e.g., RMNCH scorecard) for sustainability
- balancing ambition (“stretch”) and feasibility (“realism”);
- taking into account a reasonably even distribution of disbursements; and,
- where applicable, undisbursed amount of IDA financing for a DLI in a given year will be rolled-over for use in subsequent years.

26. 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 1).

Figure 1: Seven DLIs form a cascade of PHC-related accountability and performance at all levels



27. Table 2 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. (see Annex III for details on the DLIs).

Table 2: Summary of Disbursement Linked Indicators

Priority Area	DLIs	Indicative Attainment Schedule					Disbursement frequency & approach
		Year 1	Year 2	Year 3	Year 4	Year 5	
	DLI1: Recipient has completed all foundational activities	X	X				By each sub-activity upon achievement
Institutional Performance at all levels	DLI 2. Recipient has achieved all of the Program annual minimum conditions in institutional strengthening at all levels (national, regional, LGA and facilities)	X	X	X	X	X	Annual All-or -nothing
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
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
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
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
Capacity building	DLI 7. Completion of annual capacity building activities at all levels		X	X	X	X	Annual Sliding scale

SECTION IV

Scope and Methodology

28. To prepare the ESSA, the following activities were undertaken:
- Review of the relevant laws, regulatory frameworks, and guidelines and identification of inconsistencies with the social and environmental elements of OP/BP 9.00
 - Review and assessment of the institutional roles, responsibilities, and coordination and analysis of current capacity and performance to carry out those roles and responsibilities
 - Consideration of public participation, social inclusion, and grievance redress mechanisms.
29. The process included: (i) analysis of the national system for environmental and social management for planning and implementing programs in the health sector for consistency with the standards outlined in OP/BP 9.00; (ii) identifying where there were procedural and policy gaps with OP/BP 9.00, as well as performance constraints in carrying out environmental and social management processes; and (iii) developing a set of viable actions to strengthen the system and improve performance.
30. The baseline information/data reviewed included socioeconomic, infrastructure, and environmental (existing conditions), the potential environmental and social effects (including benefits and negative impacts) of Program activities, and systems for managing those effects.
31. The ESSA has drawn on various inputs, including:
- legal and regulatory analysis;
 - desk review of World Bank implementation reports from related projects (active related projects, Basic Health Services Project);
 - various World Bank and donor reports and Government of Tanzania statistics (including the CAS progress report, USAID ASSIST Project, National Health and Social Welfare Quality Improvement Strategic Plan, Health Care Waste Management National Policy Guidelines, National Standards and Procedures for Health Care Waste Management);
 - field visits to various primary health care centers and dispensaries to assess environmental and social conditions and institutional capacity; and
 - Meetings with government agencies, Development Partners, and other stakeholders.
32. The World Bank has worked closely with PMO-RALG, and MoHSW to develop the ESSA, and prepare the Action Plan as a guide to identify and mitigate impacts and strengthen the environmental and social management system.
33. The ESSA assessed the overall system for environmental and social impact management that will be applied to the PforR operation, which focuses on improving service delivery and strengthening systems, and financing civil works related to upgrading and improving infrastructural

conditions and utility services of the health facilities. The ESSA concludes that the environmental impacts of the Program are moderate and are associated with: (i) design and construction related impacts which are expected to be short term and localized and (ii) poorly managed health care waste which could have direct impacts on public health and environment. **Land acquisition and relocation are not envisaged, and the social footprints are expected to be limited to effective operation and management** of the primary care health centers.

34. The ESSA analysis was conducted using the Strengths-Weaknesses-Opportunities-and-Threats (SWOT) approach. The “weaknesses,” or gaps with OP/BP 9.00, are considered on two levels: (i) the system as written in laws, regulation, procedures and applied in practice; and (ii) the capacity of Program institutions to effectively implement the system.

35. The analysis focuses on the strengths, gaps, potential actions, and risks associated with the systems currently in use in the Health sector to address the environmental and social effects commensurate with the nature, scale and scope of operations. This is structured to examine arrangements for managing the environmental and social effects (i.e., benefits, impacts and risks) of the Program. The analysis also examines how the system as written in policies, laws, and regulations is applied in practice at the national and local levels. In addition, the analysis examines the efficacy and efficiency of institutional capacity to implement the system as demonstrated by performance thus far.

36. The analysis presents a scenario of whether the current system: (i) mitigates adverse impacts; (ii) provides transparency and accountability; and (iii) performs effectively in identifying and addressing environmental and social risks. The overarching objectives are to ensure that the risks and impacts of the Program activities are identified and mitigated, and to strengthen the system and build capacity to deliver the Program in a sustainable manner. This ESSA report also proposes measures to strengthen the system. The following sections translate the gaps and opportunities encountered, into a viable strategy to strengthen environmental and social management capacity and performance at the national and local levels, and NGOs/CSOs.

SECTION V National Environmental and Social management Systems

5.1 National Policy and Legislative Framework

37. Tanzania has a number of policies, instruments and laws that support environmental and social management and the environmental and social assessment processes. There are a number of sectoral directives to integrate environmental and social considerations in the decision-making process. The Constitution of Tanzania 1977 (amendments in 1988), Article II states that (i) every person has the right to self-health, and that every citizen shall be free to pursue health in a field of his choice up to the highest level according to his merits and ability, and (ii) the Government shall endeavor to ensure that there are equal and adequate opportunities to all persons to enable them to acquire health and vocational training at all levels of health facilities and other institutions of learning.

5.1.1 Environment

i) The **National Environmental Policy (1997)**: The National Environmental Policy (NEP) provides the framework for incorporating and mainstreaming environmental and social considerations into decision-making in Tanzania. The overall objectives are to:

- Ensure sustainability, security and the equitable use of resources without degrading the environment or risking health or safety
- prevent and control degradation of land, water, vegetation and air
- Conserve and enhance the natural and manmade heritage, including biological diversity of the unique ecosystems of Tanzania
- improve the condition and productivity of degraded areas, including rural and urban settlements
- Raise public awareness and understanding of the essential linkages between environment and development, and promote individual and community participation in environmental action
- Promote international cooperation on the environmental agenda

The NEP is a comprehensive attempt to guide the conservation and management of natural resources and the environment. It provides for cross-sectoral and sectoral policy guidelines, instruments for environmental policy, and the institutional arrangements for environmental management for determining priority actions and monitoring. The NEP requires environmental education and awareness-raising programs to be undertaken in order to promote informed opinions. It encourages environmental education to be introduced into primary and secondary school curricula to inculcate values that support responsible environmental care, and discourage attitudes that are incompatible with sustainable ways of life.

As stated in the NEP, the environmental objective of the Water, Sewerage and Sanitation sector is to support the overall national objective of providing clean and safe water within easy reach, to satisfy basic needs, to protect water sources and prevent environmental pollution. The NEP requires planning and implementation of water resources and other development programs in an integrated

manner and in ways that protect water catchment areas and vegetation cover and promotion of technology for efficient and safe water use.

Reviews of environmental performance are undertaken annually. There are no published documents/reports on monitoring and reviewing environmental performance. It has also not been widely distributed in the Kiswahili language, which is used by the majority of the implementers.

ii) **The Environmental Management Act No. 20 (2004):** This is a framework Act in that it is the legislation governing environmental aspects in Tanzania. It includes provisions for sustainable management of the environment, prevention and control of pollution, environmental quality standards, public participation, and the basis for the implementation of international environmental agreements. The Act sets out the mandates of various actors to undertake enforcement, compliance, review and monitoring of environmental impact assessment, to facilitate public participation in environmental decision-making and to exercise general supervision and coordination matters relating to the environment. Institutionally, it provides for the continuation of the National Environmental Management Council (NEMC), which is mandated to oversee environmental management issues and review programs to decide whether they need to undertake Environmental Impact Assessments (EIAs) and prepare Environmental Impact Statements (EISs).

The EMA has established environment units in all ministries and environmental committees at the regional, district and village levels. Within each ministry, it is the Environmental Section's responsibility to ensure that environmental concerns are integrated into the ministry's developmental planning and project implementation in a way that protects the environment.

iii) In September 2006, the GoT issued the **Healthcare Waste Management Policy Guidelines**, which were intended to ensure the proper handling and treatment of healthcare waste at different levels of health facilities. The target groups are medical staff members, national policy members, research and training institutions, NGOs and other healthcare service-related organizations. The Policy Guidelines were followed by the **National Standards and Procedures for Healthcare Waste Management**, and the **Healthcare Waste Management Monitoring Plan**.

iv) **Water Utilization (Control and Regulation) Act, (No. 42) 1974:** This Act, and its amendments, is the principal legislation dealing with the protection of water resources and control of water extraction for different uses. The extraction of water for different users is controlled through a "water right permit". The projects need to undertake the procedures for acquiring and managing water rights, discharges to open environment and maintenance of water quality, which are provided by this act.

v) **Energy and Water Utilities Regulatory Authority (EWURA), 2001:** The general functions of EWURA are to regulate the provision of water supply and sanitation services by a water authority or other person including the establishment of standards relating to equipment and tariffs chargeable for the provisions of water supply and sanitation services.

vi) **Water Supply and Sanitation Act No 12 (2009):** The Act provides the legal framework for water supply and sanitation. It outlines the responsibilities of government authorities involved in the water sector, establishes Water Supply and Sanitation Authorities as commercial entities. The National Water Sector Development Strategy 2006-2015 sets out a strategy for implementing the

National Water Policy, which aims to achieve sustainable development in the sector through an "efficient use of water resources and efforts to increase the availability of water and sanitation services." The National Water Sector Development Program of 2006-2025 sets out to promote the integration of water supply and sanitation with hygiene education.

vii) The **Occupational Health and Safety Act** No. 5 of 2003 aims to improve health, safety, and general wellbeing of workers and workplaces by promoting occupational health and safe practices in order to eliminate occupational accidents and diseases, hence achieve better productivity in the workplaces.

viii) The **Public Health Act** was enacted in 2009. The Act defines healthcare wastes (infectious wastes, pathological wastes, sharps, pharmaceuticals, gene toxics, radioactive wastes, coagulated blood wastes and drugs) and clarifies that waste management procedures should be guided by the Environment Management Act. The Act (Para. 92) instructs the relevant authorities to:

- a) ensure that health care wastes are sorted and stored in prescribed coded containers and transported in waste trucks designed and registered for that purpose;
- b) prescribe the best possible methods for final disposition of various types of health care wastes;
- c) prescribe the best possible methods for handling and the disposal of
 - (i) veterinary wastes arising from abattoirs;
 - (ii) veterinary drugs;
 - (iii) wastes emanating from agricultural activities;
- d) agro-chemical wastes;
- e) chemical wastes; where necessary, prescribe for penalties on management of animal excreta waste or sewerage or dung.

5.1.2 Social

i) Tanzania overhauled its employment and labor laws in 2004 when it enacted the **Employment and Labour Relations Act, Act No. 6 of 2004** and the **Labour Institutions Act, Act No. 7 of 2004**. While the Employment Act provides for labor standards, rights and duties, the Labour Institutions Act constitutes the governmental organs charged with the task of administering the labor laws. Subsequently, in 2007 several pieces of subsidiary legislation were promulgated to facilitate the enforcement of labor rights and standards stipulated in the Employment Act. The new laws further enact employment and labor standards which, by and large, conform to the labor standards set by the International Labour Organization.

ii) The **Employment and Labour Relations Act** sets out provisions for fundamental rights and protections, which include forced labor, child labor, discrimination, and freedom of association. It also sets out employment standards, wage parameters, working hours, and dispute regulations, among others.

While Tanzania's Constitution stipulates which laws apply across the entire United Republic, labor laws are not included. Therefore, mainland Tanzania and Zanzibar have separate legislation governing child labor. Each has a different minimum age for work and laws governing hazardous labor. Zanzibar has two different minimum ages for work. Article 100 of the Zanzibar Children's

Act of 2011 prohibits children under age 18 from working, while the Zanzibar Employment Act and Act 116 of the Zanzibar Labor Act of 2007 stipulate age 17 as the minimum age for work. In contrast, the minimum age for work on mainland Tanzania is 14. While Zanzibar clearly stipulates the prohibition of the use of children for illicit activities, mainland Tanzania does not, including involvement in the production and trafficking of drugs.

iii) **Land Policy (1997):** The Land Policy, and laws emanating from it, addresses issues of: land tenure, promotion of equitable distribution of land access to land by all citizens; improvement of land delivery systems; fair and prompt compensation when land rights are taken over or interfered with by the government; promotion of sound land information management; recognition of rights in unplanned areas; establishment of cost effective mechanisms of land survey and housing for low income families; improvement of efficiency in land management and administration and land disputes resolution, and protection of land resources from degradation for sustainable development.

iv) **Land Act No 4 of 1999.** Private property is given either through Granted Rights in General and Reserved Land (Land Act, Section 19) or through Customary Rights in Village land (Village Land Act, Section 22). Provision is also made for holding land by joint occupancy or occupancy in common (Land Act, Part XIII). This is under the Ministry of Lands and Human settlements.

v) **Village Lands Act, No. 5 of 1999:** The act requires each village to identify and register all communal land, and obtain the approval of all members of the village for identification and registration (Village Assembly, Section 13). A Register of communal land (section 13(6)) is to be maintained by each village land council, and land cannot be allocated to individuals, families or groups for private ownership (section 12(1) (a)). This is also under the Ministry of Lands and Human Settlements.

vi) **Land Act, Cap.113 R.E. 2002:** The major function of the Land Act is to promote the fundamentals of the National Land Policy by giving clear classification and tenure of land, land administration procedures, rights and incidents of land occupation, granted rights of occupancy, conversion of interests in land, dispositions affecting land, land leases, mortgaging of land, easements and analogous rights, co-occupation and partitioning and settlement of land disputes. Section 1(4) classifies Tanzanian land into three categories: Tanzanian land falls into three categories, namely:

1. Reserved Land: set aside for wildlife, forests, marine parks, etc. Specific legal regimes govern these lands under the laws which established them e.g. Wildlife Conservation Act, Cap 283, National Parks Ordinance, Marine Parks and Reserves Act, etc.
2. Village Land includes all land inside the boundaries of registered villages, with Village Councils and Village Assemblies given power to manage them. The Village Land Act, Cap 114 governs the land and gives details of how this is to be done.
3. General Land is neither reserved land nor village land and is therefore governed by the Land Act and managed by the Commissioner.

All urban land falls under General Land Category, except land which is covered by laws constituting reserved land, or that which is considered hazard land. General land is governed by the Land Act. Reserved land includes environmental protected areas as well as areas intended and set aside for spatial planning and (future) infrastructure development. Rights of occupancy are given in

two categories that separate the rights of citizens and non-citizens to occupy land. Section 19 (1) confers right to all citizens to occupy land; 19 (2) and 20(1) excludes non-citizen to occupy land except for purpose of investment (Tanzania Investment Act 1997). Property rights can be created over surveyed general land or reserved land; for a period of 33, 66 or 99 years; confirmed by a Certificate of Title.

vii) **Land Acquisition Act Cap118, 1967 R.E. 2002:** The Land Acquisition Act is the principal legislation governing the compulsory acquisition of land in Tanzania. Sections 3-18 of the Act empower the President to acquire land, and provide the procedures to be followed when doing so. The President is empowered to acquire land in any locality provided that such land is required for public purposes, and those who will be adversely affected to the acquiring of land by the government are eligible for the payment of compensation.

viii) The **Local Government Act, 1982** (revised in 2002) and its amendments, the village, district and urban authorities are responsible for planning, financing and implementing development programs within their areas of jurisdiction. Each authority has to suppress crimes, maintain peace, good order and protect the public and private property. LGAs are also capable of holding and purchasing, or acquiring and disposing of any movable or immovable properties.

ix) **Gender Policies:** There are a number of policies positively impacting gender. Important among them include the following: (i) Gender Policy, (ii) Affirmative Action Policy, (iii) Sexual Offenses Act (1998), and (iv) Action Plan against Gender Based Violence (since 2010).

x) **Rights of the Child; Rights to Reproduction and Access to good quality Reproductive Healthcare:** Tanzania is a signatory to the Universal Declaration of Human Rights and specifically to the Convention on the Rights of the Child and has submitted the 3 reports in 2013.

xii) **Constitution of Tanzania 1977(amendments in 1998, 2005)**
Article 9.

(a) that human dignity and other human rights are respected and cherished;

(f) that human dignity is preserved and upheld in accordance with the spirit of the Universal Declaration of Human Rights;

(g) that the Government and all its agencies provide equal opportunities to all citizens, men and women alike without regard to their color, tribe, religion, or station in life;

Article 13.

(4) No person shall be discriminated against by any person or any authority acting under any law or in the discharge of the functions or business of any state office.

Article 14.

Every person has the right to live and to the protection of his life by the society in accordance with law.

5.2 Institutional framework.

The main institutions with key responsibilities for environmental and social management in the health sector are described below.

i) The **Ministry of Health and Social Welfare (MOHSW)** is responsible for the overall stewardship of the health sector. The Ministry is responsible for policy development, strategic planning, resource mobilization and monitoring and evaluation in the health sector. The MKUKUTA program provides the overall guidance to development programs including those in the health sector in Tanzania. Further integration and harmonization of MOHSW activities with the MKUKUTA management and monitoring is expected in HSSP III. The Ministry issues standardized guidelines for monitoring quality control of works includes aspects related to location and siting of health facility buildings and their ancillary facilities.

As result of the policy of Decentralization by Devolution, MOHSW does not have direct responsibilities for operational service delivery at the LGA level. However, the Ministry provides guidance to service providers and monitors the quality of the service delivery. The Tanzania Quality Assurance Framework, with an accreditation system (Star rating for health facilities), will be an important new tool for the Ministry in guiding the health sector. In this system incentives (rewards and penalties) are expected to be instituted with regular monitoring and feedback to provide for remedial actions.

Under the Ministry there are semi-autonomous agencies and regulatory bodies that are assigned specific tasks. These include: Registrar of Private Hospitals, National Food Control Commission, Optical Council of Tanzania, Medical Council of Tanganyika, Pharmacy Board, Nurses and Midwives Council, Private Health Laboratories Board, Health Laboratory Technologists Council, Chief Government Chemist.

Specialized hospitals that function under the responsibility of MOHSW are expected to become referral hospitals. Training institutions (116, including private institutes) for pre-service training of paramedical staff are also directly under the Ministry. Eight Zonal Resources Centers under MOHSW provide Continuing Professional Development and support to training institutions. 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 and most PHC facilities do not even have a bank account.

Ancillary agencies include the Tanzania Food and Drugs Authority which is responsible for the control of quality of food medicines and other consumables. The Tanzania Food and Nutrition Centre (TFNC) is responsible for planning and coordinating implementation of food and nutrition programs, as well as nutrition training and research. The National Institute for Medical Research (NIMR) is responsible for carrying out, controlling, coordinating, registration, monitoring, evaluation and promoting of health research in Tanzania.

ii) The **Office of the Vice President:** The vision of the Ministry of Environment of the VPO is “to attain sustainable human development, eradication of poverty, security and equitable use of resources on a sustainable basis to meet the basic needs of the present and future generations without degrading the environment or risking health or safety and also maintain the union between the mainland Tanzania and Zanzibar”. The mission of the VPO is “to formulate policies and strategies on poverty eradication, protection of environment and non-governmental organizations as well as co-ordinate all issues pertaining to the mainland Tanzania and Zanzibar”. The VPO is responsible for overall policy guidance and advice on the development of strategic environmental

vision, including formulation, analysis and appraisal of broad environmental policy, as well as formulation and review of broad environmental goals, in conformity with such vision. The VPO provides a basis for a broad political legitimacy for the administration of strategic policy decisions on a routine and continuous basis for coordinated environmental management.

iii) The **Prime Minister's Office (PMO)** is the central office for government coordination, and also manages the Regional Administration and Local Government (**PMO-RALG**). It also houses the central office for emergency preparedness, with which the Health Emergency Preparedness Unit in MOHSW works closely. The Tanzania Commission for AIDS (TACAIDS) operates as an agency under the PMO, and provides leadership for a National Multi-sectoral Response to HIV and AIDS. It is also mandated to coordinate and strengthen efforts of all stakeholders involved in the fight against HIV and AIDS. PMO-RALG, through the Local Government Authorities (LGAs), is responsible for coordination directives to the regions and districts to ensure on the ground implementation of health initiatives at LGA levels. The Health Department in PMO-RALG oversees the overall coordination and administration of Regional Health Management Teams (RHMTs) / CHMTs in regards to health commodities activities. The RAS/ RHMT is responsible for monitoring and implementation coordination of health initiatives at LGA level.

iv) The **Ministry of Finance and Economic Affairs** has an important role in disbursement of funds for health and in accounting for the expenditure. MOFEA provides the annual budget indications, which are crucial in the planning process. Therefore there is close collaboration with this ministry. MOFEA transfers funds for health to MOHSW and earmarked funds for health directly to the LGAs, on request of MOHSW.

v) The **National Environment Management Council (NEMC)** is responsible for ensuring that development programs comply with all relevant environmental laws and regulations. It is responsible for enforcing pollution control and performs the technical arbitration role in the undertaking of EIAs. The sectoral and district environmental units are responsible for developing sectoral guidelines within the framework of the national guidelines, issuance of EIA registration forms and provide relevant information on policies and other administrative requirements. The NEMC provides periodic monitoring to ensure no adverse cumulative impacts from school construction program at the national level. It provides oversight and technical assistance to the Local Government Authorities when required.

vi) The **Occupational Safety and Health Authority (OSHA)** was set up in 2001 under the Ministry of Labour and Employment to administer occupational health and safety at workplaces in the country. The **Ministry of Labor and Employment** is the main actor with the oversight role of ensuring that decent work is practiced and maintained in Tanzania. It provides directives, technical advice, enforces legislations, proposes amendments, allocates resources, oversees all activities carried out by OSHA and ensures that OHS rules and regulations are adhered to and maintained at workplaces.

vii) **Healthcare Waste Management (HCWM)** is an area that presents particular challenges for Tanzania. MOHSW has authority to deal with HCWM issues, and a National Program for HCWM was set up in 2006 headed by a National Coordinator. However, low capacity levels and inadequate resources has hampered effective implementation of the program, and considerable effort will be

needed to ensure that there is compliance with global good practice in waste management at PHC facilities.

viii) There are a few other ministries important for elements of the health programs, e.g. **Agriculture and Food** with respect to nutrition, **Water and Energy** with respect to sanitation and water borne diseases, **Industries and Trade** with respect to international trade agreements, **Gender Women and Children** with respect to gender issues and maternal and child health, **Justice and Constitutional Affairs** with respect to health legislation. The Ministry works closely with all these ministries to achieve the strategic objectives of HSSP III. MoEVT specifically ensures participation and implementation of bonding and compulsory attachment initiatives through the Higher Learning Institutions and Higher Education Students Loans Board. Some of the students are those studying for careers in the Health sector.

ix) The **Ministry of Water and Irrigation** is the agency responsible for co-ordination, monitoring and regulating community water supply. The promotion of hygiene and sanitation rests with the Ministry of Health and Social Welfare. Due to decentralization in the water and sanitation sector, LGAs are responsible for service provision of water and sanitation in their administrative areas, with advice from the PMO-RALG.

x) Local Government Authorities (**LGAs**) are responsible for delivering three types of public services: (1) concurrent functions; (2) exclusive local functions; and (3) delegated functions. Concurrent functions are public services which are funded and regulated by the central government, but for which the provision is devolved by the sector ministries to the local government level. Health services belong to those concurrent services. LGAs review and clear the environmental and social management process prior to funding any construction or civil works program. They are responsible for:

- Ensuring health center construction programs comply with Tanzania's environmental laws and requirements
- Receiving, reviewing and commenting and clearing of health centers completed environmental and social screening forms and checklists
- Carrying out a regular monitoring regime during the planning, implementation, construction, operations and maintenance stages of health centers;
- Preparing periodic monitoring reports on the construction programs at all stages of operations and to send these reports on a regular basis to the MOHSW
- Complying with (consistent with national laws) the directives of NEMC and MOHSW

xi) All **Local Councils** produce an annual Comprehensive Council Health Plan (CCHP), which incorporates all activities of the District Health Services, and all sources of funding at the council level (government funds, locally generated funds, local donor funds, etc.). The CCHP is produced by the CHMT, with inputs from the health facilities, the non-state actors and other co-opted members, and approved by the Council Health Services Board (CHSB), which consists of community representatives, officers from other departments, and representatives from the private sector. The PMO-RALG together with the MOHSW assesses the CCHPs and gives final approval before funds can be disbursed to the LGAs. In the future, further decentralization will give more responsibilities to the health facilities to plan and manage health activities in collaboration with communities and village governments.

xii) Implementation of health related activities at primary healthcare facilities (Dispensaries, Health Centres and District Hospitals) is a responsibility of the Local Government Authorities. **Council Health Management Teams (CHMTs)** are the lowest local government level organs responsible for on the ground implementation of initiatives for primary healthcare facilities at district level. At community level, representation to Hospital, Health Centre and Dispensary Management teams is provided for. In addition a village health committee is the lowest village government structure for health related activities. Community representation in these lower level committees is increasingly being acknowledged, and encouraged to apply social accountability mechanisms and tools like the community score cards (CSC), which assesses, plans, monitors and evaluates the delivery of health services. The CSC methodology brings together service users and providers of a particular service to jointly analyze issues in a particular service area and find a common and shared way to address them.

SECTION VI

Potential Environmental and Social Effects of the Program

38. Environmental impacts of the Program are likely to be associated with construction and civil works and operations of healthcare facilities resulting in generation of health care wastes at PHC levels. Overall, the quality of policies and regulations related to health care waste management and provision of utilities, including water and sanitation is acceptable. It is the implementation of those 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 infection control, hygiene and waste management practices at PHC levels. Even though no major untoward social consequences are expected of the Program, the establishment and functionality of participatory mechanisms for transparency and information sharing, community and other stakeholders’ consultation and participation, and grievance redress are still in their infancy stages and limited in coverage. The Program has activities aimed at enhancing the application of the social accountability mechanisms to promote inclusive consultation, monitoring and feedback of all stakeholders in Program activities.

6.1 Potential Environmental Benefits and Risks

39. 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 and healthcare facility operations are well managed. Impacts are also expected to be moderate since the infrastructural rehabilitation and construction works will be confined to existing PHC premises. . The ESSA identifies the key measures to be taken for improved environmental and social due diligence in the Program and is intended to help the Government and implementing agencies in overcoming deficiencies with regard to environment, and health and safety aspects at PHC centers and institute systemic improvements.. The Program provides **an opportunity to enhance systems in ensuring safe, clean and sustainable surroundings** at PHCs, which is important not only for better management of environmental aspects but also for direct impact on health outcomes by reducing the risk of infection and preventing potential diseases. The 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*), 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*). Its broad environmental goals will be to:

- Create an infection-free, clean and hygienic environment with sound occupational health and safety practices and proper disposal of infectious wastes and wastewater.
- Create a safe and hazard-free PHC environment with easy and safe accessibility
- Conserve energy and natural resources, employ day-lighting strategies and promote habitat protection, sustainable use of locally sourced materials and water harvesting
- Improve indoor air quality and avoid exposure to toxic materials
- Employ sustainable purchasing and green practices such as waste management efforts and recycling and zero-mercury equipment.

40. The **major environmental risks** associated with the Program are primarily related to:
1. Risk of spread of infection through poorly managed healthcare waste. At PHC level, the main types of waste would include (i) sharp waste (e.g., hypodermic needles, scalpels etc.); (ii) chemical waste (e.g., reagents, solvent etc.); pathological waste (e.g., human tissues, body parts, fetus, etc.); (iii) infectious waste (e.g., blood and body fluids etc.); (iv) pharmaceutical waste (e.g. outdated medications, etc.); and (v) waste with high heavy metal content (e.g., batteries, thermometers etc.). The risks from exposure to untreated or poorly managed medical waste include HIV/AIDS and hepatitis through contact with infected sharps, gastroenteric, respiratory, and skin infections through poor disposal practices. Worldwide, it has been estimated over five million people die each year from waste related diseases. This includes healthcare workers, staff, workers in waste disposal facilities (such as landfills or incinerators), scavengers and rag-pickers and even the community. Poor practices with regard to non-infectious general waste, such as inadequate storage, poor collection and untimely disposal can attract stray animals and rag pickers and become breeding grounds for vector-borne, water-based and fecal-oral infections.
 2. Unhygienic and unsanitary conditions at healthcare facilities can increase the risk and potential for patients to get Hospital Acquired Infections (HAI). The WHO estimates that 5 to 30 percent of patients globally develop avoidable nosocomial⁵ infections during their stay in health care facilities due to lack of proper sanitation and unhygienic environment.⁶
 3. Contamination of water bodies through inadequate disposal of drug waste, expired pharmaceuticals, heavy metals such as mercury, phenols and disinfectants
 4. Toxic emissions of dioxins and furans from slow burning of unsegregated waste (from incinerators and slow-burning pits), including plastics (syringes, tubing etc) which are detrimental both to the neighboring community and also have regional and global environmental impacts.
 5. The typical environmental impacts related to rehabilitation of existing facilities include:
 - a. Design issues related to (i) provision of water and sanitation, (ii) sewage treatment if facilities are not connected to the municipal sewage connection (iii) waste disposal technology/infrastructure
 - b. During construction: (i) water logging and pollution, (ii) siltation, (iii) dust and noise nuisances, (iv) restricted access to the healthcare facility services, (v) noise, disruption and pollution caused by construction equipment and vehicles (vi) discarded rubble and possible asbestos (vii) use of lead based paints and (viii) occupational health and safety of staff, construction workers, patients and surrounding community.

⁵ Infections which are a result of treatment in a health care service unit but secondary to the patient's original condition; they appear 48 hours or more after hospital admission or within 30 days after discharge.

⁶ WHO fact file on sanitation, 10 facts on sanitation, March 20, 2008 (<http://www.who.int>).

41. A significant percentage of these potential risks can be avoided by better infection control practices and improved waste management and sanitation and hygiene conditions in healthcare facilities. The Program includes 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. This includes assessment and incentivizes improvement of infrastructure, such as sewerage and drainage, water supply, lighting and equipment for infectious waste disposal. The approach increases **accountability for quality control in managing wastes**, which has the potential to decrease risk of spread of infections and improve the public health safety standards in the country.

42. The Program is highly relevant as the number of healthcare centers are increasing at all levels of service to meet the needs of a growing population with their attendant medical needs. Thus far, the Government has made significant progress in addressing health care management policy and procedural needs, and progress in the evolution of the regulatory framework has been steady. With the support from World Bank and other stakeholders, the following activities have been implemented since the establishment of the National Action Program for HCWM in 2004:

- The National HCWM Programme established in the Ministry of Health and Social Welfare in 2006, headed by a National Coordinator (currently only two fully qualified staff, but sometimes draw upon support from the Environmental Health Section)
- National Policy Guidelines for HCWM issued in 2006, currently being revised (for issuance in February 2015)
- National Standards and Practices on HCWM issued in 2006
- National HCWM Monitoring Plan issued in 2006
- Training manuals developed under the National HCWM for healthcare workers
- Training of 32 national and regional TOTs on HCWM
- Vehicle procured to support HCWM
- Policy support for HCWM under the National Health Policy, revised in 2007

43. However, the reality is that there is weak overall institutional capacity in the sector, particularly at the LGAs and at the PHC levels where the Program will be implemented. Additionally, the regional level (RAS, RHMT) capacity to oversee, support and monitor LGAs to ensure compliance with national policies and service standards is limited. Many of the critical issues in the health sector that present perceptible risks remain largely unaddressed owing to the following issues:

Design Issues

- Unsafe building materials, such as asbestos, and low cost chemical (lead) paints used in health care buildings.
- Inadequate water supply and sanitation facilities
- Inadequate workplace conditions, including poor hygiene and unsafe or unclean facilities
- Location of PHCs in or near sources of high potential pollution such as waste disposal sites/landfills, slaughter houses, cattle-sheds, or any other potential source of infectious diseases.
- Unavailability or inadequate supply of potable water, particularly in areas where ground water has fluoride, heavy metals, or bacterial vulnerability
- Poor indoor air quality and insufficient ventilation in PHC care rooms

- Inadequate facilities and access for the physically challenged
- Poor or nonexistent disaster/fire safety and emergency response arrangements, especially if the PHCs are located in difficult sites such as hilly areas, erosion prone sites or high vulnerability areas.

Operational Issues

- Poor practices and management of healthcare waste, through inadequate segregation, collection and disposal due to:
 - lack of segregation of waste according to categories such as by type, color of bags and bins and size
 - Poor understanding of appropriate locations for waste facilities, especially siting way from potential infection transmission areas, such as labor wards
 - Poor handling of hazardous and infectious wastes, including exposure of both patients and waste handlers to such waste
 - Inadequate or non-existent waste transportation equipment
 - Poor or non-existent final disposal facilities, including old incinerators, burning pits and sealed placenta pits
- Weak institutional capacity to address environmental issues, especially health care waste
- Lack of resources to procure Personal Protective Equipment and technologies and establish health care waste management facilities, from segregation bins to specialized transportation to appropriate waste disposal sites
- Poor information dissemination systems for HCWM;
- Lack of regional/centralized disposal facilities in peri-urban and rural areas;
- Poor monitoring and database management of healthcare facilities, both public and private;
 - Poor accountability for waste management quality control; and
 - Inadequate staffing of qualified HCWM specialists at national and district levels, and HCWM handlers at all service levels (although it is not expected that dedicated handlers be available at lower service levels, there should be adequate training available to staff, particularly Clinical Officers and laboratory technicians)
- Insufficient training and awareness of healthcare staff and workers with regard to occupational safety and infectious waste management practices
- Ineffective community involvement in understanding HCWM processes and techniques that can be integrated into local health governance structures such as the District Councils, Health Facility Governing Committees (HFGC), and Village Welfare Committees;

44. Medical waste management at the health institutions shows serious weaknesses that will require long-term structural changes to be effective in responding to healthcare needs. Resources need to flow to both oversight agencies and healthcare providers. The national agencies are constrained in funding for staff, capacity building, information dissemination, and monitoring. At the district and regional levels, even with decentralized powers, there is a clear need to enhance the importance of infection control and waste management as part of the overall management of healthcare facilities. Given that many areas have rudimentary health services, even in peri-urban areas, a clear prioritization will have to be made of the current network of PHC centers and dispensaries to be able to determine whether some efficiencies can be introduced by optimizing the facilities without affecting access, thus improving quality and service levels.

45. There is significant potential for private sector involvement in HCWM disposal as some 30% of healthcare facilities throughout the country are privately-owned, the proportion greater with the inclusion of non-profits, including faith-based organizations. The overall participation of non-government owned health facilities is greater at higher service levels. Also, LGAs, under the Comprehensive Council Health Plans, have the flexibility to include higher-quality private health service providers under their block grants or pooled resources. Given that scenario, the promotion of privately-owned centralized facilities appears an attractive option for proper waste disposal, and should be examined further.

6.2 Potential Social Benefits and Risks

46. The anticipated negative social effects of the Program are not expected to be significant; while the Program does finance civil works, those will be limited to upgrading of existing PHC facilities and there are no physical interventions that are expected to have footprints in terms of loss of land or assets/livelihood etc., and land acquisition is not envisaged. So far there have been no land acquisition implications in the on-going complementary health projects under implementation by the GoT. The social implications of the interventions the program is expected to address includes among others:

- Poverty (Economic and Health Vulnerability)
- Beliefs and Traditions
- Gender responsiveness
- HIV/ AIDS
- Community and other stakeholder participation and representation in Health matters
- Existence, functionality and effectiveness of mechanisms to promote social accountability and transparency including consultations, feedback and grievance redress at village, health facility and district hospital levels.

47. The predicament in the health sector relates to high maternal and neonatal mortality, low facility deliveries and family planning coverage, low provision of obstetric care, etc., which all need great improvement. Other visible challenges like medicines stock-outs, staffing levels in the facilities, negative staff attitudes and absenteeism, pilferage of drugs and supplies, and poor accountability for health services results do exacerbate the situation.

48. Gender issues exist as in most countries where women are often disadvantaged due to different initial endowments than men. Women are poorer in terms of asset ownership (including land), finances, and human capital development (including Health status), and also due to the type of economic activities they pursue. In Tanzania, culture also greatly influences the gender balance and sustains the inequality. For example, in some localities, belief in witchcraft has placed women at risk and coupled with other factors leads to ‘Nfumu’ (traditional doctor) to be first choice for the sick. The Program, through its Social Accountability initiatives, will promote inclusive consultations and feedback (including grievance redress mechanisms) to address concerns related to choice in use of existing primary health care facilities by men and women. This, as well as GoT initiatives to improve the status of women and promote gender equality (including the establishment of the Ministry of Women Affairs and Children, the creation of a gender committee to oversee and ensure that sectoral investments respond to the priority needs of both women and

men; and the recent land legislation providing women the right to inherit, own, and dispose property), is expected to contribute to utilization of improved health care services.

49. Further, Tanzania is home to nearly 48 million people, most of who live in rural areas with limited access to reproductive health care services. As a result, 25% of Tanzanian women would like to plan their families but do not have access to contraceptives, many pregnant Tanzanian women do not receive testing or counseling for HIV, and 48% of Tanzanian mothers do not deliver their babies in a health facility as indicated by the BRN Healthcare NKRA Lab Report Part I. Similarly, day to day working relations between health care staff and patients tend to be rather predominantly relations among women, that is between nurses, and lower level staff on one hand and on the other hand women accompanying sick children and the elderly, women caring for relatives who are patients or coming for care themselves. Thus, the established importance of mother and child's health, and women's education on public health to society's health outcomes makes women's participation in health systems an important variable. Therefore representation of women on health committees is an important aspect and it is for this purpose that health sector reform initiatives that have been proposed and to be implemented have gender is an important variable.

50. A number of other issues play a major role in maintaining functionality and attendance of a health facility. This includes location to enable access, medicines and other medical supplies stocks, attitudes of health workers towards patients, staffing levels, access to information on services available, etc. These aspects too are part of the social accountability initiatives which is expected to provide opportunity for participatory monitoring and decision making, and information dissemination and feedback on services.

51. The success of new health reform initiatives require ownership by the various stakeholders groups and especially the target groups with active participation of both the community at all levels as well as the service providers. Such ownership and active participation will build trust and create conducive environment to encourage health facility attendance, resolving of facility based challenges, staff attendance and retention measures, facility performance through social accountability and community monitoring of the functioning of the health facilities and agreement on expected results. In the Program, DLI 3 which represents performance of MNCH service delivery at Primary Health Care facility, introduces an aspect of assessing facility level social accountability mechanisms through the functioning of Health Facility Governing Committees and obtaining patient satisfaction for services received and provision of incentives for such performance.

52. A number of committees exist at village level as a part of the local government system including the one on Social Welfare that deals with village management of health facilities. This committee is responsible for the oversight of the dispensary activities and resolution of complaints and grievances, following the legendary participatory administration system of village councils in Tanzania. The village council system comprises of the Chairman and members all elected representatives of the people in the village. At health facility level is the Health Facility Governing Committee (HFGC) that is established in 1999 along with the Community Health Fund that provides subsidized cost-shared support for local communities under the decentralized healthcare structure in Tanzania. The HCGC typically consist of five members from the community and three

appointed members (the health facility in-charge, a member of the village government committee and Ward Development Committee). The committees meet four times a year. According to the Ministry of Health and Social Welfare (2001), the main role of the committee is to: (i) develop the plans and budget of the facility; (ii) mobilize the community to contribute to the CHF and ensuring the availability of drugs and equipment; (iii) responsibility for reporting health provider employment and training needs to the district council, and ensuring their availability at the facility; (iv) liaising with Dispensary Management Teams (DMT) and other actors to ensure the delivery of quality health services. Constitution of the committees around the entire country and their functionality is mixed. The program through DLI4 which represents the annual performance of MNCH service delivery at the LGA levels will be assessed using a score card which considers service delivery outputs like increase of deliveries, etc., and improvements in the conditions for the provision of quality care under the government's Star Rating System.

53. Information disclosure on matters of health in Tanzania requires improvement. Generally, The Big Results Now government initiative has a scoreboard publicly accessible on the website, and results are reported to Presidents Office. However detailed information on health facilities performance in vital areas including those relevant to this Program is not yet available. The ESSA did not establish the estimated proportion of the Tanzania population that do access the internet and are be able to seek and utilize such information when made available. Despite universal growth of Information and Communication Technology (ICT) and improved access to internet in the country over the years, the Tanzania Communication Regulatory Authority (TCRA) reports the number of Tanzanians using internet to be 17% (7.5 million) of the population in 2012. The reasons for this low figure are cited as low literacy levels, poor infrastructure and unavailability of internet services in semi-urban and rural areas. In addition, establishment of systems to report performance of health facilities on social accountability that includes resolving grievances is in its infant stages. It is important that such availing of information in the public domain utilizes a wide array of channels easily accessible to and understood by the citizens (website, papers and radio). Further, stakeholders' consultative processes appear to have lost steam and dissipated as compared to the past years. Matters of primary health services delivery especially HCWM and community engagement require the participation of various groups of stakeholders and therefore MOHSW has an important part to play in getting other parties to the table. Information made available in the public domain and its applicability for improved service delivery will be part of the Program.

54. The social risks may include the following:

- Land requirements: The normal practice in the Health sector in Tanzania is for land to be contributed by either the Local Government or the community and land has not been a constraint in the past. However, for this program there is no land acquisition or land take expected in any form, due to the absence of any new civil works, hence land acquisition is not any issue and is considered a low risk.
- Exclusion and inequity: Consultations, monitoring and feedback processes and procedures for operating primary health facilities if not well designed and funded could exclude vulnerable groups of people. Similarly, elite capture of most of the incentive programs, politicization of decision making and equity between regions, and ethnic and vulnerable groups are risks that need to be carefully considered and mitigated since the program is

spread over the entire country. Mechanisms for inclusion, including participatory monitoring and feedback by multi stakeholder groups representation would provide both the status and initial corrective actions as firm mitigation measures get devised and implemented, if any signs of exclusion are visible. For example in the RBF incentives to provide services to all and to beneficiaries of TASAF at a higher rate have been instituted.

- Weak participatory planning, monitoring and decision: Participatory decision making and community involvement are major aspects of the program. Although communities are involved through the Village Social Welfare Committee and Health Facility governing Committee, their level of involvement is determined by the local government. The local government arranges for the selection of representation to both committees and is responsible for their orientation to their functions, roles and responsibilities including their facilitation to fulfill their mandates. Similarly, the service providers have an important role to play especially in providing information the package of services offered and soliciting feedback from the service users. Such a participatory approach therefore needs to take root right from planning, through monitoring the expected health results and decision making for improvements, and needs to be deliberately encouraged as opposed to passive ordinary community involvement. This effort would require effective and functional structures and systems and where they do not exist, their establishment and support is enhanced, followed by continued outreach, as well as sustainable and visible incentives.
- Delayed implementation of decisions: In Tanzania as in any other country where cash budgets prevail, delays in health service delivery and other related actions due to either financial or other resources constraints like staffing may occur. Since visible improvements in service delivery are key incentives in any reform process, both service providers at various levels and users are likely to be discouraged when effect does not occur within the expected period. Therefore commitment of higher levels of government especially those responsible for financing and staffing decisions must buy into the program activities and the suggested approach for its implementation and monitoring.
- Conflict management: Conflicts/complaint management mechanism is an important part of any development activity involving various players and particularly when new ways of working and innovations are introduced. If not addressed, weak, delayed or impractical conflict management and resolution mechanism may upset the expected outcomes. New ways of doing things include putting key information in the public domain, periodic mutual monitoring and feedback including suggestions for improvements that involve active participation of both service providers and users. Strategic communication efforts and inclusive participatory mechanisms with government, non-government and community based agencies at various levels should be encouraged for this purpose. Buy in of other actors is essential.

SECTION VII

Operational Performance and Institutional Capacity Assessment in Managing Environmental and Social Impacts

55. Based on a review of the documentation and detailed analysis of the environmental and social effects of the Program and consultations and discussions with stakeholders, the Analysis presented here is organized by each of the six Core Principles outlined in OP/BP 9.00 and synthesizes the main findings using the SWOT (Strengths-Weaknesses-Opportunities-Threats) approach, which is adapted and applied to the PforR context in the following way:

- Strengths of the system, or where it functions effectively and efficiently and is consistent with OP/BP 9.00;
- Inconsistencies and gaps (“weaknesses”) between the principles espoused in OP/BP 9.00 and capacity constraints
- Actions (“opportunities”) to strengthen the existing system.
- Risks (“threats”) to the proposed actions designed to strengthen the system.

7.1 Summary of System Assessment

Core Principle 1: General Principle of Environmental and Social Management

OP 9.00: Environmental and social management procedures and processes are designed to (a) promote environmental and social sustainability in Program design; (b) avoid, minimize or mitigate against adverse impacts; and (c) promote informed decision-making relating to a program’s environmental and social effects.

BP 9.00: Program procedures will:

- Operate within an adequate legal and regulatory framework to guide environmental and social impact assessments at the program level.
- Incorporate recognized elements of environmental and social assessment good practice, including (a) early screening of potential effects; (b) consideration of strategic, technical, and site alternatives (including the “no action” alternative); (c) explicit assessment of potential induced, cumulative, and trans-boundary impacts; (d) identification of measures to mitigate adverse environmental or social impacts that cannot be otherwise avoided or minimized; (e) clear articulation of institutional responsibilities and resources to support implementation of plans; and (f) responsiveness and accountability through stakeholder consultation, timely dissemination of program information, and responsive grievance redress measures.

Applicability

Core Principle 1 is considered in terms of environmental and social management (ESM) for the health sector, as a key component of good service delivery (i.e. measures included under the Program’s system-strengthening measures for enhanced accountability and oversight mechanisms).

Summary Findings

There is an adequate national regulatory framework in Tanzania and technical guidelines exist for environmental and social due diligence with respect to the potential impacts of the Program. There are also environmental and social procedures under existing World Bank-funded health programs, which have been deemed satisfactory. However implementation has not been up to standards and the assessed

weaknesses are systemic, related to insufficient resources – both financial and manpower - for overseeing and monitoring of implementation of environmental and social measures, timely procurement of consumables, weak coordination and inadequate attention to environmental concerns. Additionally there is need to strengthen and update some of the technical guidelines for asbestos management, incinerator usage and management and environmental enhancements related to sanitation, water and energy efficiency.

System Strengths

In the MOHSW and PMO-RALG there is recognition of environmental sustainability and the desire for Program interventions to contribute towards improved sanitation, reduced pollution and a better quality of life, as well as strengthened institutions. Field studies and consultations carried out as part of this analysis show that there is a willingness to address issues that are compromising efficient and effective application of environment and social management processes in the sector.

The analysis noted that direct larger environmental (related to construction) and social impacts in the health sector can, and have been, adequately managed. Ongoing health programs in Tanzania have environmental and social practices that have been accepted and are being implemented reasonably satisfactorily.

Supervision reports and field visits have confirmed that impacts have been modest and measures to mitigate potential impacts have had reasonable success in being implemented. The current process is designed to ensure that the environmental and social assessment process is part of and conducted during the planning stages with full participation of the local community, thereby ensuring that program activities are environmentally and socially sustainable.

There are technical guidelines and standard designs for PHC centers that are presently being used/or newly prepared by the MOHSW. These include guidelines for siting and locations of PHC facilities, including land use zoning conditions; designs for buildings, ventilation, water supply and sanitation, waste management for laboratories, kitchen designs, sanitation arrangements, use of safe local

Gaps

Weak implementation: ESSA field interviews and program supervision reports indicate that although the direct impacts and risks are generally modest, environmental management activities are weak in some areas, such as systematic inspection, monitoring and enforcement. This is primarily due to (i) weak and insufficient *institutional and technical capacity*; (ii) inadequate resources, including manpower, *technology and equipment*; (iii) inadequate *training, monitoring and enforcement*; and (iv) weak *inter-institutional and coordination* between the various related agencies.

The Healthcare Waste Management Program is severely ***under-resourced (manpower and funds)*** which prevents it from providing satisfactory oversight.

There also could be *limited awareness* of environmental health risks associated with poor quality of water, *inadequate sanitation and hygiene*, which prevents adequate attention be paid to these issues.

Poor implementation of ***waste management practices and unsafe disposal*** can result in environmental pollution and public health risks. Poor management of construction waste and poor implementation of mitigation measures during construction can have impacts on public safety and environmental pollution. Poor disposal of asbestos can be risky if damaged or recycled. Poorly run incinerators, slow-burning pits where unsegregated waste is burnt are commonplace among health facilities and need to be managed with increased operational training and regular maintenance. Other gaps in implementation include *insufficient waste management equipment* and their poor and inaccurate utilization. ***Storage of medication*** without appropriate power back-up can render them ineffective or expired.

The ***environmental and social impact assessment*** requirements under EMA are comprehensive although there are gaps related to categorization of risks, screening, and impact analysis and auditing as compared to Core Principles of OP/BP 9.00. However, the risk is low since the Program supported by the Bank does not

<p>materials and worker safety and rubble management requirements during construction works</p> <p>There are Healthcare Waste management Plans, ESMF and other technical guidelines and standards on medical waste management and monitoring.</p> <p>Similarly, technical guidelines for the establishment of committees at health facility and village level for purposes of inclusive consultations, feedback and decision making on proposed activities are available.</p> <p>Guidelines for the constitution of Health Facility Governing Committees with stakeholders representation exist and have been distributed followed by a directive on their application.</p> <p>Guidelines and training program for social accountability mechanisms that include grievance mechanisms exist.</p> <p>The Big Results Now a government program has a scoreboard publicly accessible on the website, and results are reported to Presidents Office.</p>	<p>involve construction.</p> <p>Technical guidelines need updating to include emerging issues such as (i) greener solutions in new buildings, (ii) ways of retrofitting old buildings with recycling and energy efficient measures. New guidelines for climate adaptation and resilience measures will need to be developed.</p> <p>Public disclosure of documents for those programs requiring a full ESIA is a requirement. But the actual process of public review and comments can be onerous and public hearings are at NEMC’s discretion during the ESIA review and approval process.</p> <p>Under EMA, there is a procedure related to grievances with respect to decisions about granting the EIA certificate. There is no requirement that ESMPs include a mechanism for handling grievances, though ESMPs in Development Partner-funded programs do tend to include them. There are processes at the local level for handling general grievances and disputes, although it has been difficult to assess if this functions well in practice to resolve grievances tied to environmental and social impacts.</p> <p>In addition, it is not clear if all health facilities in the country have fully constituted governing committees and where they exist if they function fully to ably apply social accountability mechanisms. Further currently application of the social accountability mechanisms and other participatory tools are isolated.</p> <p>ESSA field visits indicated constitution of the facility committees as mixed and functionality weak. Further, roles and responsibilities between council and health facility committees appear unclear including their expected collaboration.</p> <p>Participatory Planning, implementation and monitoring of development activities including those that are health related, which has been legendary following the Ujamaa ideology appears very weak.</p> <p>Further, information on performance of primary health care facilities especially on resolving key challenges using participatory mechanisms is not readily available and access to internet services is low especially among the semi urban and rural population. It is therefore not clear how the population would have access to the vital information and use it for influencing primary health care service delivery.</p>
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<p>Actions and Opportunities Technical Guidance and Implementation Capacity: There is opportunity to strengthen implementation capacity for monitoring, evaluation and reporting, along with public participation and disclosure. Additionally systemic changes to promote sustainable and “greener” building designs will allow better resource management. Strengthening cooperation and inter-sectoral coordination around the environmental issues and use of Environmental and Social Management Frameworks/Plans would improve their implementation.</p>	<p>Risks Poor management and oversight of PHC facilities, especially on the management and disposal of infectious healthcare wastes, can have significant effects on the health and wellbeing of communities, leading to unacceptable health and performance indicators. Weak healthy facility committees and in some cases their inexistence affect progress in the achievement of inclusive consultations, feedback and decision making outcomes.</p>
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Core Principle 2: Natural Habitats and Physical Cultural Resources

<p>OP 9.00: Environmental and social management procedures and processes are designed to avoid, minimize and mitigate against adverse effects on natural habitats and physical cultural resources resulting from program.</p>	
<p>BP 9.00: As relevant, the program to be supported:</p> <ul style="list-style-type: none"> • Includes appropriate measures for early identification and screening of potentially important biodiversity and cultural resource areas. • Supports and promotes the conservation, maintenance, and rehabilitation of natural habitats; avoids the significant conversion or degradation of critical natural habitats, and if avoiding the significant conversion of natural habitats is not technically feasible, includes measures to mitigate or offset impacts or program activities. • Takes into account potential adverse effects on physical cultural property and, as warranted, provides adequate measures to avoid, minimize, or mitigate such effects. 	
<p>Applicability The provisions in Core Principle 2 are considered as part of the ESIA process analyzed under Core Principle 1. The analysis confirmed that Program investments would neither impact nor convert critical natural habitats. This Core Principle will not be applicable to the Program and the PforR as new PHC centers will not be constructed and rehabilitation will be undertaken in existing facilities within program-funded sites.</p>	
<p>System Strengths The Tanzanian ESIA process considers physical cultural resources, including screening for archaeological, historical and cultural sites. The assessment shows that impacts on cultural sites are taken into account in program design and implementation and appropriate mitigation measures adopted. Aside from the provisions of the EMA, National Environmental Action Plan (2013-18), Forest Policy 2007, Wildlife Policy 2007, among other relevant regulatory activities, the</p>	<p>Gaps There are no significant inconsistencies between OP/BP 9.00 and Tanzania’s policies, laws, and regulations related to natural habitats.</p>

<p>GoT is revising the National Biodiversity Strategy and Action Plan of 2001 to be able to meet the UN Aichi Biodiversity Targets agreed in 2010, which will set the parameters for conservation and natural habitats – aquatic, terrestrial and agri-biodiversity. This has also been strengthened by the establishment of a national coordinating body that will oversee all aspects, from environmental safeguards to information dissemination.</p>	
<p>Actions and Opportunities The opportunities and actions identified for strengthening the system for Core Principle 1 are applicable to Core Principle 2.</p>	<p>Risks The risks identified for strengthening the system for Core Principle 1 are applicable to Core Principle 2.</p>

Core Principle 3: Public and Worker Safety

<p><i>OP 9.00:</i> Environmental and social management procedures and processes are designed to protect public and worker safety against the potential risks associated with (a) construction and/or operations of facilities or other operational practices developed or promoted under the program; (b) exposure to toxic chemicals, hazardous wastes, and otherwise dangerous materials; and (c) reconstruction or rehabilitation of infrastructure located in areas prone to natural hazards.</p>	
<p><i>BP 9.00:</i></p> <ul style="list-style-type: none"> • Promotes community, individual, and worker safety through the safe design, construction, operation, and maintenance of physical infrastructure, or in carrying out activities that may be dependent on such infrastructure with safety measures, inspections, or remedial works incorporated as needed. • Promotes use of recognized good practice in the production, management, storage, transport, and disposal of hazardous materials generated through program construction or operations; and promotes use of integrated pest management practices to manage or reduce pests or disease vectors; and provides training for workers involved in the production, procurement, storage, transport, use, and disposal of hazardous chemicals in accordance with international guidelines and conventions. • Includes measures to avoid, minimize, or mitigate community, individual, and worker risks when program activities are located within areas prone to natural hazards such as floods, hurricanes, earthquakes, or other severe weather or climate events. 	
<p>Applicability The provisions in Core Principle 3 are considered as part of the ESIA process analysed under Core Principle 1. Complementing that analysis the review found that Core Principle 3 is applicable to the Program as there is physical infrastructure being financed and issues related to medical waste.</p>	
<p>Strengths By law in Tanzania it is the duty of local governments to provide for the health and safety of the public. The EMA and regulations contain several provisions for public and worker safety, which are consistent with OP/B</p>	<p>Gaps Public and worker safety are adequately covered in the EMA regulations and the CRB, and no major inconsistencies between the system and Core Principle 3. However, the worker safety provisions are not always included in civil works contracts.</p>

<p>P 9.00. The ESIA process contains robust procedures for worker safety, requiring plans for accident prevention as well for health and safety of workers and communities, which are also part of contracts for civil works.</p> <p>Tanzania has a Contractor Registration Board (CRB) that monitors and enforces occupational health and safety regulations. The Rules of Conduct requires that contractors must maintain accident registers, provide workers with protective gear, and standards for construction sites.</p>	<p>Other gaps identified in Core Principle 1 are also applicable to Core Principle 3.</p>
<p>Actions and Opportunities</p> <p>The opportunities and actions identified for strengthening the system for Core Principle 1 are applicable to Core Principle 3.</p>	<p>Risks</p> <p>The risks identified for strengthening the system for Core Principle 1 are applicable to Core Principle 3.</p>

Core Principle 4: Land Acquisition

OP 9.00: Land acquisition and loss of access to natural resources are managed in a way that avoids or minimizes displacement, and affected people are assisted in improving, or at least restoring, their livelihoods and living standards.

BP 9.00: As relevant, the program to be supported:

- Avoids or minimizes land acquisition and related adverse impacts;
- Identifies and addresses economic and social impacts caused by land acquisition or loss of access to natural resources, including those affecting people who may lack full legal rights to assets or resources they use or occupy;
- Provides compensation sufficient to purchase replacement assets of equivalent value and to meet any necessary transitional expenses, paid prior to taking of land or restricting access;
- Provides supplemental livelihood improvement or restoration measures if taking of land causes loss of income-generating opportunity (e.g., loss of crop production or employment); and
- Restores or replaces public infrastructure and community services that may be adversely affected.

Applicability and Summary Findings

In the absence of any civil works, the risk of impacts on loss of land/asset/ formal and informal livelihood etc., from land acquisition are not likely. Based on experience in similar health projects there has been no relocation or other related impacts. Similarly, loss of access to natural resources is also a low risk. This principle therefore does not apply to the Program as no land will be acquired and there will be no economic or physical displacement.

System Strengths

Clear staff roles and responsibilities:

While the Land Act does not yet have regulations that outline a process for land acquisition, but for this health related

Gaps

While the content of the screening and analysis for Environmental and Social Impact Assessment (ESIA) under EMA are comprehensive with respect to the principles of

activities, land is contributed by the Local Government or the community and is often communal land.

Grievance procedures and dispute resolution There is a system where complaints are channeled upward, starting with the *Mtaa*⁷, Ward Executive Officer, District Commissioner, then to the Region, and up to MLHSD. If still unsatisfied PAPs can seek recourse for grievances in the courts (specifically the Court of Land Arbitration).

Consultations: Community land consultations is an internal process, and followed at the community level to ensure there is consensus on the donated land and if there are impacts on any group community mitigation measures are undertaken. For land acquisition, the valuation process includes a sensitization meeting with PAPs, which must be attended by local leaders as well. The intent is to explain the program, the valuation process, valuation rates, and arrangements for physical inspection of properties.

Analysis and Guidance There is good guidance on resettlement and compensation in Tanzania that goes beyond the Land Act and Regulations – there has been a comprehensive gap analysis between World Bank OP 4.12 and the Tanzanian system, and all of the elements of Core Principle 4 are visible in any existing Resettlement Policy Framework for Bank supported projects. Furthermore for any unanticipated emerging risk, any of the RPF will be used to provide guidelines for mitigating the land acquisition related risks.

OP/BP 9.00, there are gaps in the content of ESIA requirements, including: (i) The screening process does not explicitly take into account: Land acquisition and resettlement (although this is not an issue in this program), restricted access to resources, and Vulnerable and Marginalized groups; If land acquisition be invoked the gaps would need to be filled. However the risk related to land acquisition is low, given that the program is not expected to acquire land for construction purposes and the focus of the program is on quality, capacity and performance of the sector.

While there are policy gaps between OP/BP 9.00 and the Tanzanian system for land acquisition and resettlement, there are no direct conflicts between the Tanzanian land laws and OP/BP 9.00, which indicates that gap-filling measures in the Program (if required) will not be contrary to the law should it be required.

Tenure: Tanzanian law has clear procedures for landholders and generally extends eligibility for compensation to recognized or customary land users or occupiers lacking full title, but does not recognize tenants, squatters or encroachers as being entitled to assistance or any allowances for transportation, disturbances, etc.

Market value: Tanzania law provides for the calculation of compensation on the basis of the market value of the lost land and unexhausted improvements, plus a disturbance, movement, and accommodation allowance, and loss of profits where applicable. However, the depreciated replacement cost approach is used, that does not result in full replacement cost of the lost assets which is inconsistent with OP/BP 9.00. Additionally, market values and valuation procedures tend to be outdated and there is little baseline data for land values, which risks the valuation being at the discretion of the Land Valuation Officer.

Lost Assets and Livelihood Restoration:

⁷ A small urban area or geographical division of a ward.

	<p>“Replacement assets” under the Land Act in Tanzania are restricted to land and developments on land, and where relevant, loss of profits. OP/BP 9.00 goes beyond physical assets and includes livelihoods and standard of living, seeking to improve them or at least to restore them to pre-displacement levels. While profit losses are included in Tanzanian law, this is more narrowly defined as formal business profits and compensation for crops. While the Land Act does entitle compensation for business losses, there are no legal provisions requiring the government to restore livelihoods or to provide assistance towards the restoration of such livelihoods. Land users such as tenant farmers are only entitled to compensation for crops (the valuation method is outlined in the 2001 Regulations).</p> <p>Payment of Compensation: Legally, compensation for the acquired land should be ‘fair’ and is to be paid “promptly,” but does not have to be paid before possession of land is taken. However the terms ‘fair’ and ‘promptly’ are not defined.</p> <p>Community Infrastructure: It does not appear that public infrastructure is specifically addressed in the Land Act and Regulations. For projects/programs prioritized and implemented by the community, risks that community infrastructure will be impacted is low where most of the work will be on existing land and if required, the communities decide what land to offer to the program as donation.</p> <p>Consultation and Disclosure: As resettlement in practice is done as part of the ESIA, consultation and disclosure generally follow this process with the addition of a sensitization meeting with PAPs as part of the valuation process. PAPs are also publicly informed toward the end of the process when they can collect their compensation payments. Community Development Officers have a role during this process as well, as do Ward Officers. However, this process is geared only toward the land valuation process, and may not include tenants, informal land users, and other</p>
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	types of resettlement and compensation that are not covered by Tanzanian law. For this program consultation and disclosure will happen but compensation is not expected to be required in the absence of land acquisition by this Program.
<p>Actions and Opportunities</p> <p><i>Technical Guidance and Implementation Capacity:</i> Because the Program is not expected to lead to involuntary resettlement and compensation, in the present Program, focus of the training will be on consultations, grievance redress/conflict management etc.</p>	<p>Risks</p> <p>The risk of not addressing the gaps identified described above, could result in inconsistency with the Core Principles of OP/BP 9.00, if there is large scale land acquisition that is unmitigated. The risk is low since there is no land acquisition and its related impacts in this program.</p>

Core Principle 5: Indigenous Peoples and Vulnerable Groups

OP 9.00: Due consideration is given to cultural appropriateness of, and equitable access to, program benefits giving special attention to rights and interests of Indigenous Peoples and to the needs or concerns of vulnerable groups.

- BP 9.00:*
- Undertakes free, prior, and informed consultations if Indigenous Peoples are potentially affected (positively or negatively) to determine whether there is broad community support for the program.
 - Ensures that Indigenous Peoples can participate in devising opportunities to benefit from exploitation of customary resources or indigenous knowledge, the latter (indigenous knowledge) to include the consent of the Indigenous Peoples.
 - Gives attention to groups vulnerable to hardship or disadvantage, including as relevant the poor, the disabled, women and children, the elderly, or marginalized ethnic groups. If necessary, special measures are taken to promote equitable access to program benefits.

Applicability and Summary Findings

Resettlement and environmental degradation tend to disproportionately impact the poor and vulnerable groups, documented in both academic studies on environmental justice in Tanzania as well as operational documents for other Bank projects/programs. The analysis confirmed that, at present, there is currently no specific legislation or policy in place in Tanzania on or for Indigenous Peoples.

While considering the applicability of this Core Principle, the analysis found that it was relevant in terms of ensuring that vulnerable and marginalized groups are included in the planning process (especially needs prioritization), implementation and monitoring of program activities; that vulnerable groups have access to program benefits; and that the needs of vulnerable groups are considered with respect to the Programs impacts. For the ESSA analysis of vulnerable groups focused on those defined in the Tanzania Participatory Poverty Assessment: children, persons with disabilities, youths (unemployed, females, youths with unreliable incomes), people living with long illnesses (e.g. HIV/AIDS, TB, etc.), women (female headed households, widows and those not able to support themselves), drug addicts

and alcoholics. The approach of the Government is to ensure that all vulnerable groups are consulted and benefit from Government programs.

<p>System Strengths</p> <p>The ESIA process in Tanzania does take into account social issues in screening, impact assessment, and mitigation measures. Part of NEMC’s screening criteria for ESIA’s is to assess if impacts vary by social group or gender, and if resources are impacted that vulnerable groups depend upon. Additionally, there is currently an initiative within NEMC and supported by donors to better mainstream social issues such as gender and HIV/AIDS in the ESIA process.</p> <p>Tanzania also has policies specific to vulnerable groups such the National Gender Policy and National Policy on HIV/AIDS, in order to prevent discrimination and promote equity. There is also strong guidance for community participatory planning by PMO-RALG through the “Opportunities and Obstacles to Development Handbook”, which promotes inclusion of vulnerable groups throughout the planning process. Such process is followed by the Tanzania Social Action Fund (TASAF) to support the poor in participating communities across the country.</p> <p>Technical guidelines for the establishment of committees at health facility and village level that promote community representation for purposes of inclusive consultations, feedback and decision making in program activities are outlined in the GoT system documents. These council and health facility committees are also expected to promote SAc mechanisms and apply the community score card and other tools.</p>	<p>Gaps</p> <p>The analysis identified a number of critical gaps in the system as written, including:</p> <p>Identification of Vulnerable Groups: Vulnerable and marginalized groups are not explicitly included in the screening process for ESIA through EMA or in the Tanzanian system for land acquisition and resettlement.</p> <p>Indigenous Peoples: As mentioned above, there is no system in place that defines Indigenous Peoples in Tanzania.</p> <p>Resettlement: This requires further examination, but there are particular issues with respect to gender and vulnerability in the practice of resettlement and compensation. As mentioned above, there are no specific requirements for considering gender and vulnerability in resettlement and compensation processes beyond payment of compensation for lost land. However, for this Program that is not an issue since no involuntary resettlement is expected.</p> <p>The experience with vulnerable and marginalized groups of PAPs could benefit from further information and action – it is clear that at least in donor-funded programs with Resettlement Action Plans, vulnerability is screened for and taken into consideration; however, there is little information on how vulnerability is considered in the actual practice of compensation and/or relocation where necessary.</p> <p>Social Accountability Mechanisms: Weak healthy facility committees and in some cases their inexistence affect progress in the achievement of inclusive consultation, monitoring and feedback outcomes.</p> <p>Monitoring: Monitoring of gender, poverty, and HIV/AIDS in the development planning process is in need of strengthening. In the health sector there is no common method of analysis and collection of baseline to aid development planning on these issues.</p>
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<p>Actions and Opportunities</p> <p>Technical Guidance and Implementation Capacity: While there are some criteria for vulnerable groups in the ESIA process, these need to be strengthened. If requested by the Government, the project may support the current undertaking by NEMC to better mainstream gender and HIV/AIDS in the environmental and social assessment process.</p> <p>Addressing Resource Constraints: It is unclear if any staff in the health sector is trained to provide inputs on identifying, consulting with, and assisting vulnerable groups that may be impacted by the types of activities that will be financed with the Unreached People Group (UPG) and/or promoting social inclusion in the development planning process. The Program capacity building and training plan can include measures for good practices on inclusive consultations, monitoring and feedback of all groups of people.</p> <p>Higher Order Opportunities: The Bank is currently discussing its policy regarding Indigenous peoples with the Government. As the ESSA is intended to be a living document the results of these discussions will be incorporated as relevant once completed.</p>	<p>Risks</p> <p>It is clear from the analysis that if the gaps identified and opportunities presented in this core principle (where applicable) are not addressed; the Program would be at risk of not generating the desired environmental and social effects and would remain inconsistent with the guiding principles of OP/BP 9.00.</p>
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Core Principle 6: Social Conflict

<p><i>OP 9.00:</i> Avoid exacerbating social conflict, especially in fragile states, post-conflict areas, or areas subject to territorial disputes.</p>
<p><i>BP 9.00:</i> Considers conflict risks, including distributional equity and cultural sensitivities.</p>
<p>The Program will not entail social conflict in fragile states, post-conflict areas or areas subject to territorial disputes, nor will the Program cause social conflict or impact distributional equity or associated cultural sensitivities. As such, the ESSA did not consider the Program with regards to Core Principle 6 as this Core principle and key element are not applicable to the Program. It is important to note that distributional equity and cultural sensitivities are covered under the analysis of system with respect to the main considerations of Core Principle 5.</p>

7.2 Integrated Risk Assessment

56. Based on the findings of the ESSA Analysis, the following table aggregates the risks discussed above, and proposed measures to mitigate those risks. These are included in the Program’s integrated risk assessment.

Risk Description	Risk Management
<p><i>Potential Environmental and Social Impacts</i> of Program are not identified, mitigated, and monitored; Program scope is changed to include construction or large-scale civil works.</p>	<p>Overall, the potential environment and social risks of the Program are site-specific, moderate, straightforward and manageable, related primarily to construction management, occupational health and safety, construction and healthcare wastes. While technical guidelines and standards exist, inadequate capacity and insufficient resources (Human and funds) can result in poor implementation, inadequate enforcement and monitoring, which could result in poor mitigation of potential impacts.</p> <p>The ESMF prepared for the Regional Health Systems Strengthening Project defines measures for strengthening institutional systems and capacity building measures to monitor environment and social impacts. Implementation has been poor due to insufficient resources, inadequate capacity and poor monitoring. The processes and measures laid out in the ESMF are applicable to the Program and will be strengthened, and included in the Program Operational Manual, and monitored for improved implementation.</p> <p>Under the Government of Tanzania’s “Star Rating” accreditation initiative, each facility will have a quality improvement plan and efforts will be made to help such a facility achieve a higher Star Rating.</p> <p>Monitoring and supervision of due diligence measures related to environmental and social issues will be a part of World Bank supervision. The program will include a process of ongoing consultations and a capacity building and training program to ensure implementation of measures meet the needs of the beneficiaries. The details of implementation will be included in the Program Operations Manual. The Program’s annual capacity building plans are expected to help address this issue.</p>
<p><i>Exclusion in consultations, monitoring and feedback.</i> The likelihood that some groups of people and those in hard to reach</p>	<p>Overall the SAc indicators score indicate very little is being done to provide for the ‘demand side’ of decision making and management of health services. In addition the lower level health facility governing and council health</p>

<p>areas may be excluded from the planned social accountability mechanisms aimed at improving health care services exists.</p>	<p>committees are not fully functional. The Program will therefore require a strengthened and incentivized SAc system which demands community engagement plans as part of the Comprehensive Council Health plans.</p>
<p><i>Weak Participatory Planning, Monitoring and Decision Making:</i> Participatory decision making based on inclusive planning is no longer the norm. Communities appear to have no information on services delivered and have limited opportunities to engage or provide feedback on health service delivery. Formalized and effective complaint redress mechanism to address social and environmental issues do not function as in the past years.</p>	<p>Program will strengthen the existing systems that allow the community and other stakeholders to be represented in the Village Social Welfare Committee and health facility governing committees to be fully constituted and functional. This is provided for under the assessment of performance for health facilities and that for LGAs. The committees will work towards public information dissemination.</p>
<p><i>Staffing and skills mix</i> in the Program is insufficient to handle environmental and social management issues</p>	<p>The Program will assess capacity needs of staff for environmental and social management and ensure that all necessary staffing is available with adequate skills. The Program will appoint focal points for Environmental and Social for monitoring and implementation of the ESSA. The Program will be incentivized to provide adequate resources to environmental and social management. Training on costing, implementation and monitoring of Environmental and Social actions and Grievance Redress mechanisms will be included in capacity building program.</p>
<p><i>Annual Performance Audit</i> does not include the requirement or the technical expertise to assess performance of the ESSA</p>	<p>Terms of Reference for consultants will ensure that adequate skills are hired to assess environmental and social management systems along with social audits/social accountability and implementation of ESSA</p>
<p><i>Delayed Implementation of decisions.</i> Due to financial and other constraints, key decisions may take long to come to fruition. This can discourage those responsible for key improvements in service delivery.</p>	<p>Champion identification, buy in and consensus building among key stakeholders is critical. In addition information dissemination and awareness raising activities for environmental and social due diligence measures will be built into the Program.</p>

SECTION VIII
Recommended Measures to Strengthen Systems Performance

8.1 System Performance Strengthening

57. The Program ESSA analysis presented above identifies strengths, gaps and opportunities in Tanzania’s environmental and social management system with respect to effectively addressing the environmental and social risks associated with the Program. This section converts these gaps and opportunities into a viable strategy to strengthen environmental and social management capacity and performance at the national and local level.

58. The analysis identified 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: Health Care Waste Management and Social Accountability. These could be further defined during the consultation process and during implementation, as required. The ESSA therefore identifies the following key measures to be taken for improved environmental and social due diligence in the Program.

Measures to Strengthen System Performance for Environmental and Social Management	
Objective	Measures
Defining the System for Environmental and Social Management	<p>While the Program does not have a significant environmental footprint, and with no 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.</p> <p>The Program will follow the measures defined in the existing Environmental and Social Management Framework (ESMF) prepared as part of the World Bank-financed Regional Health Systems Strengthening 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.</p> <p>The ESMF has been assessed and found to be compliant with OP/BP 9.00 principles but needs updating, with 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 along with improved focus on gender and other vulnerable groups also needs improvement.</p> <p>The Program will require increased coordination among various ministries, agencies and donor partners on environmental and social aspects to further support implementation. The process and criteria for monitoring, enforcement and reporting on environmental and social measures will be part of overall Program reporting and data management.</p> <p>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).</p> <p>The above requirements, processes and systems will be included in the Program Operations Manual.</p> <p>Monitoring and supervision of the ESSA implementation will be a part of World Bank supervision.</p>

<p>Technical Guidance and Implementation Capacity</p>	<p>The ESSA identifies the need for improved and updated technical guidance for better waste management (health care and construction), asbestos and incinerator management, occupational safety and hygiene practices, enhanced transparency and information sharing, grievance redress, and community participation.</p> <p>Follow up on the implementation of the HCWM and Community Engagement Plans will be a part of World Bank supervision.</p>
<p>Addressing Capacity Constraints</p>	<p>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.</p> <p>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.</p> <p>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.</p>
<p>Improved systems for Information Disclosure and Stakeholder Consultation</p>	<p>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 increased 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.</p> <p>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.</p>

8.2 The Grievance/Complaint Redress Mechanism

59. National Level: At the national level there is a government portal available for registering complaints. In addition, the Health sector will also have a portal that can be used for registering complaints. The existence of this mechanism needs to be widely disseminated in the format and language understood by the citizens using all media channels accessible to them. In addition the implementers of both the portals need to have a person identified for integrating the complaints into the community score card for discussion with the service providers and monitored for redress. The Open Government Project in the pipeline will also assist in this area and lay out a streamlined process that can be followed by all government ministries.

60. Local Level: The following systems are in place at the local level:

- LGAs have a complaint box to receive complaints and depending on the issues raised, either provide resolutions or include in the community score card for mutual discussions and addressing.

- Village Health Committees also have a similar mechanism for handling complaint. They respond to the complainant or forward to the next higher level for redress of issues that are beyond their jurisdiction
- Health Centre and District Hospitals Governing Committees are responsible to receive and resolve complaints.

The Operational Manual of the Program will need to review the existing system and provide timelines and a monitoring mechanism for the grievance redress mechanism (GRM). The GRM will also need to be widely disseminated to all stakeholders.

61. Communities and individuals who believe that they are adversely affected by a World Bank supported project may submit complaints to existing project-level grievance redress mechanisms or the Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address project-related concerns. Project affected communities and individuals may submit their complaint to the World Bank's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WB non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an opportunity to respond⁸.

⁸ For information on submitting complaints to the World Bank's corporate Grievance Redress Service (GRS), <http://www.worldbank.org/GRS>.
For information on submitting complaints to the World Bank Inspection Panel: www.inspectionpanel.org.

SECTION IX Stakeholders Consultations

62. 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. At present, the ESSA consultation process is embedded in the Program consultation process. Feedback from stakeholders has been instrumental in designing and revising the program Action Plan, indicators, and technical manual.

63. Consultations: Initial consultations held by the government with a large group of stakeholders over a period of time led to the formulation of BRN in Health Program as a part of the overall BRN. The outcomes of those consultations are embedded in this program and influenced its design. For the preparation of this ESSA, Bank specialists undertook meetings and consultations with different stakeholders including government agencies, development/funding partners, civil society, and some field work, including visits to healthcare facilities. Supervision Aide-memoires were reviewed for understanding the implementation record of complementary Bank funded projects. Further consultations were undertaken during appraisal and consisted of consultations with a large group of stakeholders along with smaller meetings with selected stakeholders. (See Annex II for the list of participants).

64. Document Dissemination and Public Comments Period: The final draft ESSA will be publicly disclosed and shared with the donor partners and stakeholders involved with environmental and social management issues in Tanzania. The final report will be translated in Swahili and disclosed publicly as well as in Infoshop.

65. Consultation Event: A public consultation was held where the ESSA was presented and stakeholders were invited to offer inputs on the findings and recommended actions in an interactive format. Other consultations were undertaken during field visits. List of participants is in Annex II.

66. The issues discussed and information provided during the various interviews and field visits detailed in table below:

Issues Raised	Response
Where are the incentives in the program? Some of the issues identified are as a result of absence of an incentive structure to help health staff cope with the poor environment they are working in. Some programs have compensatory measures for staff. In addition shortage of qualified specialists in the health facilities is also quite a challenge.	The Program will work within existing systems and structures of government. Compensation is a government responsibility. The responsibility will be with the health facility to identify measures to put in place in order to achieve the indicators of performance. The performance incentives are that about 70% of the resources earned by the health facility will be used on the health facility and the facility will decide how to use the 30% in a participatory and transparent manner.

<p>Health care waste management is a big challenge in Tanzania. The guidelines and detailed standards were prepared and disseminated through a directive to lower levels as far as Health Management teams since 2006, but not implemented. However the technology was found unaffordable and not compatible / environmentally sound and the health facilities resorted unsafe disposal. In addition the health facilities do not even accept the responsibility of health care waste management. In addition, some health workers are not even aware how to handle the waste. Could incinerator technologies and centralized disposal facilities including the costs of transporting the waste be considered?</p>	<p>Very small works to improve the facility or make it more functional for example installation of a rain water harvesting system may be undertaken by the facility to help improve hygiene.</p> <p>Other capacity building activities may be undertaken by the hospital when identified as key issues that need to be addressed.</p>
<p>Facility designs for existing health facilities do not enable hygiene practices. This includes absence of basic needs like water and sanitation facilities. How will the program help?</p>	<p>The program facilitates the health facility to identify its challenges and together the facility management and the responsible council and governing committee would find ways of addressing the challenges within the available resources. Very small works to improve the facility or make it more functional for example installation of a rain water harvesting system may be undertaken by the facility to help improve hygiene.</p> <p>The program will not finance civil works for new buildings or ancillary facilities.</p>
<p>Guidelines for the composition of health facility committees with representation of community, women, staff, etc. have been issued. Some facilities have them and working well while others do not. However their working also depends on the In-charge (is also the secretary of the committee) who must be cooperative even though the BRN program urges health committees to be active. Communities are at the center of this change. Issuing directives is not the answer. Committees must be resuscitated and communities informed of whatever is going on. The responsibility of the committee is also to build capacity of its members and the community served by the facility.</p>	<p>This was a suggestion to be considered to include community engagement in the health council plans if not already done.</p>
<p>The government came up with a directive that PMO-RALG should find out if committees</p>	<p>The health facility has to decide how to use the 30% of the funds it has obtained to</p>

have regular meetings, use participatory planning, etc. But the members of the committee say they have to walk 5 miles to the meeting venue, don't eat throughout the day and have to return home, etc. What will be given to the committee members to encourage them to attend meetings, follow up on actions, etc.?	resolve issues that need attention. However this has to be done in a participatory and transparent manner.
Government has for some time procured equipment for primary health care facilities that has become obsolete and needs to be disposed of. Is this included in the waste management plan?	The decision to dispose of used equipment is for the health facility and the relevant authorities to decide. If the waste is significant this can be one of the issues to be discussed by the facility and a decision made in a participatory and transparent manner.
There is lack of awareness in people about environmental and social issues in construction works.	Noted. The Program will include an awareness and information dissemination component to address this issue
Overall monitoring needs to be strengthened	The Program provides for enhanced monitoring
What if results are not achieved ? Will there be no funding?	There are measures for course correction and some DLIs have the provision for catching up. Funding is pro-rated in terms of results achieved.
What are outcomes ? Is it better performance? How will it be measured?	Outcomes are a part of the performance. Other components of the program will all contribute towards the outcome Short and long term outcomes will be monitored
Who should be on the health facility governing board/ committee ?	This is well provided for in the CHSB guidelines for both trainers and establishment. They are distributed to all councils. This program will scale up efforts to orient communities to these guidelines. This is reflected in the ESSA.
Will the service providers really discuss with us the changes they are ready to make and we agree?	There will be a facilitated process between you the users and the providers so that you all agree on what the issues are and the key actions to take. Moreover the health facility will be rewarded for this change and you will be asked to give feedback on the changes you see if any. The information is detailed in the SAC tools methodology and training guide.
There is a need to reach out to other stakeholders for implementation support on issue such as water & sanitation, waste management and recycling, social accountability, etc.	This has been reflected in the ESSA and it is a responsibility of MoHSW to initiate contacts and collaboration with other actors starting at national level.

Possible conflict in land acquisition.	This would be considered as an issue in cases of construction that poses land acquisition with resettlement and/or relocation. Presently this Program does not envisage any land acquisition and therefore this is not relevant for this program
The Health sector is inclusive of all groups.	Information reflected in the ESSA

ANNEXURES

Annex I Environmental Impact Assessment (EIA) Process in Tanzania

The key steps of the EIA process are:

Registration: The proponent is required to register a project with NEMC by submitting duly filled EIA application form. The forms are available at NEMC.

Screening: Screening is an initial review step in the EIA process. Thus, the EIA application forms and Project Brief are screened in order to assess and establish the category of project and determine the level of EIA required. This is done by NEMC within 5 working days after submission of EIA application forms.

Scoping: If the screening indicates that a full EIA is required, identification of main issues of concern through scoping will be conducted by the developer through his Consultant. This is done by consulting all the relevant concerned parties. Draft terms of references (ToR) will then be prepared to guide the impact assessment study. A Scoping Report and draft Terms of Reference (ToR) are submitted to NEMC for review and approval. This is done within 10 days after submission of the Scoping Report.

Impact Assessment: Conducting EIA study is done after approval of ToR by NEMC. The Consultant uses the ToR to conduct the actual EIA study. The crucial task is to identify likely impacts, assess and evaluate their severity and magnitude and propose mitigation measures to minimise potential negative impacts and enhance positive benefits. The output of this stage is an EIA report, also known as Environmental Impact Statement (EIS). This includes an Environmental Management plan (EMP) as well as a Monitoring Plan (MP) that outline management and monitoring of anticipated impacts, including those, which affect local communities in the project area. Public consultation is mandatory when conducting an EIA and the proponent (through his consultant) must meet key stakeholders to get their views.

Review: Once the proponent has submitted an EIA report (EIS), NEMC conducts site verification visit. The site visit is conducted to verify information provided in the EIS report. NEMC then coordinates a cross-sectoral Technical Advisory Committee (TAC) to review the EIS. The TAC is composed of members from sectors responsible for environment and resource management. Review of EIS is completed by NEMC within 60 days from the date it was received by NEMC, and this is as required by EMA 2004. The Minister may within 30 days, upon receipt of recommendations of the Council approve or disapprove the EIS.

Public hearing: As part of the review process a public hearing may be necessary to address public concerns over a proposed activity or project. Normally this takes place when major concerns have been raised by the public and potential negative impacts of the proposed project are perceived to be far reaching. Other critical factors that may necessitate public hearing are sensitivity of the site location, type and scale of project, technology used, multiple land use considerations, presence of relocation and resettlement issues, cumulative impacts and any other factor related to a particular project that might cause public concern.

Environmental Decision-Making: After submission of the final version of the EIS, NEMC assesses it in order to ascertain whether all the TAC comments and recommendations have been adequately addressed by the consultant. Thereafter terms and conditions for issuance of the EIA Certificate are prepared by NEMC. Approval/disapproval of the EIS is done by the Minister responsible for Environment as stipulated in EMA 2004 section 92 (1).

Appeals: Both the proponent and the affected or interested parties have the right to appeal. If there is dissatisfaction on the decision reached, provision for appeal to the Environmental Tribunal or Court of law is provided by law.

Project Implementation: This is conducted according to the terms and conditions of approval and is guided by the Environmental Management and Monitoring Plans.

Monitoring: It is the collection of data through a series of repetitive measurements of environmental parameters (or more generally, a process of systematic observation) over a long period to provide information on characteristics and functioning of environmental and social variables in space and time. Day to day internal monitoring (routine monitoring) is done by the developer (project management team), but compliance monitoring is done by NEMC in collaboration with key stakeholders and regulatory bodies.

Environmental Audit: Environmental audit is an independent and objective oriented examination of whether the practice complies with expected standards. Broadly, environmental audit means a check on some aspects of environmental management, and implies some kind of testing and verification. There are two levels of Environmental Audits, i.e. Environmental Impact Audit and Environmental Management Audit. Environmental Impact Audit involves comparing the impacts predicted in an EIS with those that actually occur after implementation of the project while Environmental Management Audit involves checks against adherence to plans, mitigation measures and general compliance of terms and conditions.

Annex II
List of Persons Consulted

Consultations on the ESSA, social issues and healthcare waste management practices in Tanzania included meetings the following persons:

Ministry of Health and Social Welfare
Environmental Health Section

Healthcare Waste Management Program
Honest Aneticus, National Coordinator
Noah Mwasalujonja, HCWM Specialist

Regional Health Office

Mhando Muya, Regional Health Officer, P__ Region
Solomon Werema, District Health Officer, Kabiha
Augusta Njau, Health Administrator, Tumbi Hospital

Health Centers

Sister Sangu, Mkoani Health Center
Lilian Masuri, Clinical Officer, Kongowe Dispensary

DFID

SIDA

World Bank

Rekha Menon, Lead Economist and Program Leader
Son-Nam Nguyen, Lead Health Specialist
Petronella Vergeer, Senior Health Specialist
Yahya Ipuge, Health Specialist
Jane Kibassa, Senior Environment Specialist

Field Visits (3 February 2015)

Tumbi Regional Hospital, Kibaha
Medway Health Center
Mkaoni Primary Health Care Center
Kongowe Dispensary
Mwendapole Dispensary

ESSA Stakeholder Consultation Meeting (Thursday 26/02/2015)

Location: World Bank Offices in Dar es Salaam

Participants:

1	Honest Anicetus – MOHSW	National Coordinator Healthcare Waste Management
2	Noah L. Mwasalujonja – MOHSW	Public Health Officer
3	Eric Mugurusi	Environmental Climate Change consultant
4	Shukuru Nyagawa	E-link Consult Ltd
5	Raymond Mcharo	TAMWA
6	Barnabas Jachi	TASAF
7	Fatma M. Kitundu	Rahman Social Development Network
8	Fadhila Mkony	MOHSW
9	Erneus Kaijage	Eco Consult Associates
10	Mapunda John Ansgar	
11	Paul Chilewa (TEC)	Tanzania Episcopal
12	Gloria Mafole	CCT
13	Petro Pamba	CSSC
14	Francis Gugu	Shivyawata
15	Masud George	Legal and Human Rights Centre

Annex III

DLI 1: Recipient has completed all foundational activities

1. *DLI Description:* DLI1 is the completion of foundational activities to ensure a robust system-level framework or the Program. It has six results related to the preparations for capacity building, data quality improvement, fiscal decentralization, facility accreditation and availability of BEmONC and CEmONC services in the five BRN MNCH regions. Each result has an allocation, and disbursement is made on sliding scale basis.

2. *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)

3. *DLI Description:* DLI 2 is the completion of 6 Program results in institutional strengthening which GOT needs to meet every year. Each results 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) and 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.

4. *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

5. *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 (e.g. availability of essential supplies and equipment, water, health care waste management, infection control practices, facility-level accountability

mechanisms (e.g. 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.

6. 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 CAG 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).

7. 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.

8. *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 32 pay-for-performance programs at the provider level supported by the World Bank globally. 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:

- 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.

DLI 4: LGAs have improved annual Maternal, Neonatal and Child Health service delivery and quality as measured by the LGA Balance Score Card

9. *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 RMNCH 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"

Disbursement for this DLI will be made annually and on a sliding scale basis.

10. *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 balanced 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.

11. 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 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 actual 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.

12. 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 Card

13. *DLI Description:* 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.

14. *Theory of Change:* This is the first time in Tanzania, 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 lower levels (LGA and facilities).

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

15. *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 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 finance 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.

16. *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 balanced 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 stimulate 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

17. *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.

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

Annex IV
Reference to Typical Waste Management and Monitoring Plan⁹

Issue	Responsible Authority	Cost	Responsible Authority for Monitoring	Recommended Frequency/Times of Monitoring	Monitoring Indicators	Monitoring Cost (\$)
National Level						
Facilitate Set-up Health Care Waste Management Facility plans and Coordination Team at district level	MOHSW		MOHSW/LGAs		-Number of Healthcare facilities with healthcare waste management plan -Number of healthcare facilities with designation HCWMO	
Dissemination of acceptable procedure of HCWM and requirements for Health Care Waste disposal technologies			MOHSW		List of acceptable procedure and standard of HCWM	
Facilitate Appointment : 1) HCWMO in Referral, Regional and District Hospitals; 2) Officers in charge in Health centre and Dispensaries			MOHSW/LGAs		Number of Hospitals with designated Officers for monitoring healthcare waste activities	
Conduct monitoring, \supervision and research on ongoing healthcare waste interventions			MOHSW		Number of health care facilities supervised in healthcare interventions	
Negotiate with the private Sector for establishment of recommended disposal systems in all cities with particular emphasis to Installation of centralized treatment			MOHSW/LGAs		Number of centralized treatment and disposal options in urban areas	
Equip all large HCFs with segregation, packaging, collection material (including protective			MOHSW		Number of HCF with essential HCWM equipment's	

⁹ Adapted from *Health Systems Strengthening Project*. 2010. ESMF. Annex 7. Relevant Ministries and Departments to be identified for oversight functions.

clothes), transportation and disposal equipments						
Conduct awareness campaign Policy makers • Health facility personnel/staff • General Community/population.			MOHSW		Number of awareness sessions conducted in healthcare waste management	
Provide Technical training for the Health Officers of the MOHSW, National Institutions (CEDHA, MUCHS,) Regional and District Authorities (train ‘trainers of trainers’)			MOHSW/CEDHA		Number of Health officers trained in technical aspects of healthcare waste	
Set-up-in-service Training Programmes in regional Centres for medical, paramedical and technical staff			MOHSW/CEDHA			
Review curricula in health institutions to incorporate HCWM			MOHSW/MUHAS/KC MC/BUGANDO		Number of professional curriculum reviewed	
Recruit new staff members at the MOHSW			MOHSW		Number of Professionals recruited for healthcare waste management Programme	
Support Regional and District Hospitals with construction of high tech medical waste incinerators			MOHSW		Number of HCF with high tech incinerator	
Review and incorporate technical aspects related to provision of water supply and sanitation facilities and hand washing facilities in the Ministry Construction guides for Healthcare Facilities			MOHSW		Revised building technical guidelines for the provision of water and sanitation and hand washing facilities	
Establish a National database and information management for HCWM			MOHSW/UDSM		Database and information management system	
Train Healthcare workers on healthcare waste management and infection prevention and control country wise			MOHSW		Number of healthcare workers trained in healthcare waste and infection prevention and control	
Support HCWM Program with office running cost(fuel, Computers,			MOHSW		List of items procured to support HCWM programme	

Office consumable)					office	
Develop IEC promotion materials for HCWM			MOHSW		Types and list of IEC materials developed and distributed	
DISTRICT LEVEL and FACILITY LEVEL						
WASTE PRODUCTION AND GENERAL ISSUES						
Develop facility based plans	LGAs, HMT		MOHSW	Continuously during development of plans	Draft and final Plans	
Construct Incinerators	Contractor LGAs MOHSW		MOHSW	During design and during construction	Approved designs and contract schedules	
Purchase initial supplies for waste management equipment to include safety boxes			LGAs, MSD	Once on making estimates and requisitions. Once after purchase	Purchase requisitions, delivery notes and receipts	
Purchase Occupational Health and Safety /Personal Protective Equipment (PPEs)	LGAs, HMT		MOHSW	Once on making estimates and requisitions. Once after purchase	Number and types of PPEs procured	
Procure and install water storage tanks	Contractor		MOHSW	Once on making estimates and requisitions Once after purchase During construction	Purchase requisitions, delivery notes and receipts Contract and Specifications	
Develop and implement public social mobilization/ awareness	LGAs, HMTMOHSW		Laboratory Manager	Continuously during preparation of plans and during implementation	Number of people accepting and participating in the project	
Ensure set-up of laboratory is conducive for easy and safe working	Laboratory Supervisor		Laboratory Manager	Monthly	Number of accidents related to laboratory setup	
Availability of appropriate laboratory chemicals / materials to avoid or minimize waste	Laboratory Supervisor		Laboratory Manager	Monthly	Number of items Purchased according to recommended list	
Minimize movement of people in the work area	HMT		Laboratory Manager	All the time	Number of times unauthorized persons found in laboratory	
Use color-coded waste bins in appropriate positions	HMT		Laboratory Manager	Quarterly	Number of bins in recommended places	
Segregation and storage of waste	HMT		Laboratory Manager	Monthly	Number of waste	

into marked bins					streams used	
Place disposable and reusable materials separately	HMT		Laboratory manager	Monthly	Number of cases of misplacement of reusables	
WASTE TRANSPORTATION						
Ensure internal safe movement of covered carts/bins for waste	HMT		HCWMO	Quarterly	Number of carts as recommended	
Ensure availability of staff specifically designated for waste movement	HMT		HCWMO	Monthly	Number of positions filled on the establishment form	
Ensure availability and use of appropriate tools, protective wear and safety equipment	HMT		HCWMO	Quarterly	Number of Healthcare workers having and using PPE	
Provide covered trucks for movement of waste to distant disposal site where necessary	MOHSW LGA		VPO-Envt	Every six months	Number of working trucks available as recommended	
Follow defined routes of waste (loaded carts) movement	HMT		HCWMO	Daily	Number of carts using the designated route	
Ensure availability of washing and disinfecting material for staff	HCWMO		HMT	Daily	Quantity of disinfectant available in recommended places	
TREATMENT AND DISPOSAL						
Ensure availability and use of appropriate tools and PPE for personnel at disposal sites	HCWMO		HCWMO	Quarterly	Number of people having and using PPE	
Ensure appropriate method of treatment is used for each type of waste	HCWMO		VPO-Envt	Monthly	Monthly Number of complaints against poor waste treatment and disposal	
Install incinerators with air pollution treatment facilities	MoHSW		MoEnvt	Monthly	Number of HCF with installed incinerators that meet Air quality	
DISPOSAL SITE LOCATION						
All year round accessibility to disposal site	LGA		MoEnvt	Biannually	Number of cases of failure to access site	

Location of disposal site to be: - Far from habited areas - On a leeward side - Far from reach of animals - Low water table sites	LGA		MoEnvt	As necessary during disposal facility siting	Number of complaints from neighboring residents Ground water quality	
GENERAL COMPLIANCE						
Use of appropriate technology	MOHSW		MoEnvt	Quarterly	Number of complaints on poor waste management	
General health and safety of workers, employees and public	MOHSW		MoEnvt	Quarterly	Number of complaints against health and safety	
Control Nuisance (air pollution, dust, smell and aesthetics)	MOHSW LGA		MoEnvt	Quarterly	Number of complaints against nuisance	
Set measures that prevent water pollution	MOHSW LGA		MoEnvt Ministry responsible for Water Resources	Quarterly	Water quality	

Annex V REFERENCES

Technical Reports and Government Sources

In addition to the laws, policies, and regulations cited in this report, the ESSA has drawn from a range of sources including academic journals, Government documents, technical reports, evaluations, and project documents. This annex lists some of key sources that were consulted in the preparation of the ESSA.

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