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APPRAISAL STAGE

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I. Country Context

1. Tanzania's gross domestic product (GDP) growth has remained stable at around seven 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 from over 19.0 percent in 2011 to 5.9 percent in 2014 thanks to tight monetary policy and falling international energy and food prices. However, fiscal space has been reduced during the past four years as a result of lower-than-expected domestic revenue collection, diminishing aid disbursements, and higher investment in infrastructure projects.

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

3. In 2000, Tanzania adopted the Tanzania Development Vision 2025, which aims to have a society that is characterized by (i) quality livelihood, (ii) peace, stability and harmony, (iii) good governance and rule of law, (iv) an educated and learning society, and (v) a vibrant and competitive economy by 2025. Tanzania's National Strategy for Growth and Poverty Reduction (MKUKUTA II 2010/11 – 2014/15) has three priorities: (i) growth and reduction of income poverty; (ii) improvement of quality of life and social well-being; and (iii) good governance and accountability. It explicitly identifies as priority areas human resources for health (HRH), maternal health, and improvement in health facilities and service delivery.

II. Sectoral (or multi-sectoral) and Institutional Context

4. Over the last 10 years, Tanzania has successfully reduced death rates in younger age groups, including surpassing the Millennium Development Goals (MDG) for reducing child mortality. Between

1999 and 2010, infant mortality fell from 99 to 51 per 1,000 live births, while under-five mortality declined from 147 to 81 per 1,000 live births[1]. A 2008 Lancet article on child survival gains in Tanzania[2] attributed a large proportion of these improvements to investments in health systems and scaling up specific interventions through a decentralized approach. These include 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 coverage of full vaccination and vitamin A supplementation, and improved functioning of Integrated Management of Childhood Illness (IMCI) at the facility and community levels.

5. Despite progress, Tanzania's health outcomes are worse off than expected for its level of economic development. Communicable diseases remain the major burden of mortality and morbidity for the population. Progress in reducing 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.[3] There is also a persistently high level of stunting (42 percent among children under five years of age), affecting over 3 million children (Table 2).

6. Physical access to health services has significantly increased in Tanzania with the construction and renovation of PHC facilities in rural areas. Most people are living within 5 to 10 km from a clinic.[4] On the demand side, there are initiatives to: (i) provides cash transfers to extremely poor households conditional on their utilization of health services and (ii) enroll such poor households in Community Health Funds to provide financial protection.

7. However, low quality of care remains a major bottlene**ck.** In many cases, low quality of care reduces utilization of services. For example, there are studies showing that community perceptions of the quality of the local health system influence women's decisions to deliver in a clinic.[5] An example of low quality is facilities' poor compliance with service standards for basic and comprehensive emergency obstetric and neonatal care (BEmNOC and CEmNOC). According to the Service Delivery Indicators Survey (SDI 2014), although three-quarters of all health facilities are supposed to offer services for women to give birth which is a critical need in a high fertility environment, a mere 8.1 percent of those surveyed could be deemed compliant with the offering of BEmNOC. Only 4.2 percent of dispensaries surveyed offered the full BEmNOC package. This proportion increases only to 18.5 percent for health centers and a paltry 48.6 percent for first level hospitals (SDI, 2014).

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

- Tanzania spends significantly less on health, in terms of public spending as a share of total government spending, than comparable countries and budget execution is poor. Health financing is highly dependent on external support (which accounted for 48 percent of total public expenditure on health in 2011/12), and such support is fragmented with a significant share being off-budget. Public expenditure on heath has been flat in real terms, while the share of health in the Government's budget has declined from 11.9 percent in 2010/11 to 8.7

[1] Tanzania Demographic and Health Survey (TDHS), 2010.
[2] Masanja, H., et al, *Child survival gains in Tanzania: analysis of data from demographic and health surveys*, The Lancet, 2008; 371: 1276–83.
[3] Ibid.
[4] *Tanzania Demographic and Health Survey 2007*. Dar es Salaam: Bureau of Statistics Planning Commission of Tanzania; 2007.
[5] Kruk ME, Rockers PC, Mbaruku G, Paczkowski MM, and Galea S. *Community and health system factors associated with facility delivery in rural Tanzania: a multilevel analysis*. Health Policy. 2010 Oct;97(2-3):209-16.

percent in 2013/14.

- Service delivered is hindered by the lack of skilled human resources in health (HRH). Nation-wide, there are 554 dispensaries without skilled health workers. Instead, they are staffed by medical attendants who are not qualified to manage patients by themselves. The national average ratio of clinicians and nurses per 10,000 population is low at 7.7 (compared to 22.8 as per WHO recommendations). Although Dar es Salaam which according to the recent 2012 census represents just 10 percent of Tanzania's population, it is home to 45 percent of the doctors[6] and slightly less than 20 percent of the country's health personnel. On the other hand, rural areas where more than 70 percent of the population lives only have 28 percent of the health workforce and even fewer (9.1 percent) of the doctors.

- 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 primary health care (PHC) facilities do not even have a bank account. Funding for PHC is channeled to Local Government Authorities (LGAs) which often serve as a major bottleneck preventing resources to reach lower levels.

- Accountability for results is poor at all levels, especially between (i) central government and LGAs, (ii) LGAs and facilities and (iii) facilities and communities. More than half of health workers are either absent or late during work hours. According to SDI (2014), although on average 14.3 percent of health providers in surveyed facilities were absent from the facility, absence was more prevalent in Dar es Salaam where 1 out of 5 (20.7 percent) were in fact found in the facilities. Moreover, doctors especially those in urban areas are the most likely to be absent and their absence is more likely to not have been approved. There is limited adherence to good clinical practices. A review of clinicians' ability to manage maternal and neonatal complications under the SDI 2014 showed that providers surveyed adhered to only 30.4 percent of the clinical guidelines for managing maternal and newborn complications. There was no significant difference between the performance of public and private (for- and not-for-profit) providers. Doctors are again more likely to adhere more closely although they would follow only about 35.7 percent of guidelines. Further, essential drugs are frequently out of stock, and facilities are in poor conditions.

- There has been limited progress in engaging the private health sector through Public Private Partnerships (PPPs).

9. The Mid-term Review (MTR) for the Health Sector Strategic Plan (HSSP) III FY09--FY15 concluded that the health sector is making progress in all strategic areas, but the overall pace is slower than anticipated, with more progress in systems development (policies, strategies, guidelines, work plans, etc.) than in improving service delivery. [7] 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) increasing transparency and accountability by showing results and engaging the community in strengthening the health services and improving quality. In sum,

6 Notwithstanding that this does not include higher level hospitals which themselves are concentrated in Dar es Salaam and are the facilities that have the highest number of doctors.

[7] Tanzania Ministry of Health and Social Welfare, *Health Sector Strategic Plan III, "Partnerships for Delivering the MDGs", July 2009 – June 2015, Mid Term Review*, October 2013.

there is a need for greater emphasis on improving health outcomes in combination with sustainable service delivery systems; harmonization of processes is not an end in itself.

10. 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 (BRN in Health). BRN in Health is embedded in the medium-term Fourth Health Sector Strategic Plan (HSSP IV – FY16-FY20) which guides health sector development in Tanzania. The 2015-2018 Big Results Now in Health program aims to accelerate the reduction of maternal and neonatal mortality through improving performance, governance and accountability in primary health care (PHC).

III. Program Scope

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

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

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

- *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) fiscal decentralization at the facility level, (iii) performance contracts and targets at individual health worker levels, and, (iv) social accountability mechanisms.
- *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.
- *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.
- *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.

14. As a front runner country for the GFF, the Government of Tanzania is in the process of developing a RMNACH Investment Case in line with its existing strategies and policies namely the Big Results Now, Sharpened One Plan II, Health Sector Strategy IV which have been developed in a consultative manner based on existing evidence. Drawing on its long term vision for the sector the Investment Case will identify priorities for scaled investments to fast track progress on RMNACH goals. The Investment Case will also build on the CRVS strategy and the Health Financing strategy both awaiting parliament endorsement. The consultation process for the development of the Investment Case built on existing RMNCH and Health Financing platforms which include representation of development partners, civil society and private sector. This Program supports the operationalization of this investment case and recognizes that this would only be the first, though critical, step towards the realization of the GFF vision to end preventable maternal, newborn, child and adolescent deaths.

15. A core objective of the GFF is to support countries to harmonize RMNCAH financing and to move towards sustainability by harnessing domestic resources. The draft health financing strategy outlines several key strategies to realize the above vision and includes (i) creating fiscal space through efficiencies (ii) better defining functions of key actors including purchasing and provision (iii) value for money through adding a performance element to capitation payments linked to quality. The Disbursement Linked Indicators of this program builds on these priorities and outlines targets for (i) increases in recurrent domestic financing (ii) building capacity of institutions involved in purchasing and provision and, (iii) value for money by paying for performance at health facilities and LGA level.

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

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

18. The entire PHC component (including BRN in Health) in HSSP IV constitutes the Program which the operation supports. The scope of the proposed Program includes recurrent and operating costs, goods, small works and services. However, it excludes high-risk activities, defined as those that: (i) are judged to be likely to have significant adverse impacts that are sensitive, diverse, or unprecedented on the environment and/or affected the population; and/or (ii) involve procurement of goods, works, and services under high-value contracts.

IV. Program Development Objective(s)

19. 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.

V. Environmental and Social Effects

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

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

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

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

24. The ESSA identifies strengths, gaps and opportunities in Tanzania's environmental and social management system with respect to addressing the environmental and social risks associated with the Program. The analysis identifies the following main areas for action in order to ensure that the Program interventions are aligned with the Core Principles 1, 3 and 5 of OP/BP 9.00 applicable to the Program: Health Care Waste Management and Social Accountability. These could be further defined during the consultation process and during implementation, as required.

VI. Financing

25. The total cost of the Program is estimated at US$ 2.62 billion or 55 percent of the GOT's health sector budget over the next five years, of which US$280 million (10.7% of the total Program cost) will be financed under the proposed PforR.

Source	Amount (US$ million)	% of total
IDA (PforR)	200	7.6%
GFF (co-financing)	40	1.5%

USAID TF (co-financing)	40	1.5%
Sub-Total	280	10.7%
Other development partners (parallel financing)	290	11.1%
Government	2,050	78.2%
Total Program Cost	***2,620***	***100.0%***

VII. Program Institutional and Implementation Arrangements

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

27. The MOHSW, as the steward of the health system, is responsible for health policies, strategies, regulations, coordination and oversight for the sector and the Program. It leads the development of Health Sector Strategic Plans (HSSP) and the medium term expenditure framework for the sector on a rolling basis. The MOHSW provides oversight over autonomous and semi-autonomous national institutions responsible for key health sector functions such as managing the health commodities supply chain, regulation of food and medicines and operating the pre-paid health care financing scheme i.e., the Medical Stores Department (MSD), Tanzania Food and Drugs Authority (TFDA) and National Health Insurance Fund (NHIF) respectively. The Medium Term Expenditure Framework (MTEF) is the key document used in determining health sector budget allocations.

28. PMORALG, through the LGAs, is responsible for coordinating, providing administrative support and allocating resources for the delivery of PHC services. Funds for development and recurrent expenses are transferred from the Treasury to the LGAs, and from the LGAs to the health facilities. LGAs ensure proper accounting at the facility level. PMORALG facilitates LGAs to provide quality health services and manages the critical interfaces with MOF, MOHSW, DPs and LGAs. PMORALG monitors the support provided to Local Government Authorities by Regional Administrative Secretariats (RAS). PMORALG is also responsible for providing advice, information and capacity building to RAS and LGAs policies, approaches, systems and planning methodologies. The Council Health Management Team (CHMT) manages district healthcare services and plays an important role in planning and decision-making at the LGA level. It reports to the District Council. At the Regional Level, the Regional Health Management Team (RHMT) provides technical support to LGAs for the implementation of the Program, identify capacity building needs and monitor, supervise, and evaluate health services and conduct data quality audits.

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

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

agencies.

31. The GOT has developed a facility based incentive scheme called Results Based Financing (RBF) which will be used to pay facilities based on their performance. This scheme provides quarterly incentive payment to PHC facilities according to their levels of achievement of a set of performance indicators which are independently verified. Phase 1 of the roll-out of this scheme will cover at least 7 regions by 2020. The scheme's implementation and institutional arrangements too have been mainstreamed into current government structures and are as follows:

- ✓ The regulatory role of developing policies, guiding documents and tools as well as providing clinical and technical oversight and supervision for implementation will be the responsibility of the Ministry of Health and Social Welfare (MOHSW). In its department of Policy and Planning, a national team has been established which oversees the implementation and roll out of the scheme on a day-to-day basis.
- ✓ The National Health Insurance Fund (NHIF) as the largest public health insurer in Tanzania will carry out the role of purchaser. The NHIF will enter into agreements with providers of health and/or management services, of a specified quality.

- ✓ The providers of primary health care services consist of Public Health Facilities (with at least 1 star rating) as well as select private health facilities (with 1 star or more) in those areas where service gaps exist or with whom service agreements are already in place for select services. Council and Regional Health Management Teams as well as Medical Stores Department (MSD) and their Strategic Business Units (SBUs) will furthermore be paid based on their performance.

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

- ✓ The payment will be made on a quarterly basis by the Ministry of Finance, as the so-called fund holder, directly in to the relevant providers' bank account.

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

VIII. Contact point

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