

FIDUCIARY SYSTEMS ASSESSMENT

TANZANIA – STRENGTHENING PRIMARY HEALTH CARE SERVICES FOR RESULTS

MARCH 2015

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Acronyms

ACG	Anti-Corruption Guideline	NKRA	National Key Results Area
AFROSAI-E	African Organization of Supreme Audit Institutions in English-speaking Africa	OP/BP	Operational Policy/Bank Procedure
		PCCA	Prevention and Combating of Corruption Act
AO	Accounting Office	PCCB	Prevention and Combat of Corruption Bureau
BRNH	Big Results Now for Health	PDB	Presidents Delivery Bureau
CAG	Comptroller and Auditor General	PE	Procuring Entity
CF	Consolidated Fund	PEFA	Public Expenditure and Financial Accountability
CHM	Complaint Handling Mechanisms		
DLI	Disbursement Linked Indicator	PEMANDU	Performance and Delivery Unit (Malaysian Prime Minister)
DP	Development Partners	PFM	Public Financial Management
F&C	Fraud and Corruption	PFMRP	Public Finance Management Reform Program
GoT	Government of Tanzania		
GPSA	Government Procurement Services Agency	PforR	Program-for-Results
HCF	Health Care Facilities	PI	Performance Indicator
HR	Human Resources	PMO	Prime Minister's Office
IDA	International Development Association	PMO-RALG	Prime Minister's Office Regional Administration and Local Government
FSA	Fiduciary Systems Assessment		
IFMS	Integrated Financial Management Information System	PMU	Procurement Management Unit
INT	Integrity Vice Presidency, World Bank	PPA	Public Procurement Act
INTOSAI	International Organization of Supreme Audit Institutions	PPAA	Public Procurement Appeals Authority
IPSAS	International Public Sector Accounting Standards	PPRA	Public Procurement Regulatory Authority
IT	Information Technology	PRSC	Poverty Reduction Support Credit
LGA	Local Government Authority	PS	Permanent Secretary
LAAM	Local Authority Accounting Manual	HFGB	Health facility governing Board
LAFM	Local Authority Financial Memorandum	SIDA	Swedish International Development Cooperation Agency
MDA	Ministries, Departments and Agencies	TA	Technical Assistance
MDU	Ministry Delivery Unit	TANESCO	Tanzania Electric Supply Company
		TB	Tender Board
MoHSW	Ministry of Health and Social Welfare	TBD	To Be Determined
MoF	Ministry of Finance	TDC	Transformation Delivery Council
MoU	Memorandum of Understanding	TZs/Shs	Tanzanian Shillings
NAO	National Audit Office	USAID	United States Agency for International Development
NCB	National Competitive Bidding	VFM	Value for Money
		WDC	Ward Development Committee

FIDUCIARY SYSTEMS ASSESSMENT

1 Executive Summary

1. The objective of the Fiduciary Systems Assessment (FSA) was to examine whether Program systems provide reasonable assurance that the financing proceeds will be used for their intended purposes, with due attention to the principles of economy, efficiency, effectiveness, transparency, and accountability. The financial management systems were assessed to gauge the extent to which the planning, budgeting, accounting, controls, funds flow, financial reporting and auditing systems and practices provide a reasonable assurance on the appropriate use of Program funds and safeguarding of its assets. Equally, the Program procurement systems have also been assessed to establish the extent to which the planning, bidding, evaluation, contract award and contract administration arrangements and practices provide a reasonable assurance in support of achievement of the program results. In addition, the assessment considered how Program governance systems manage the risks of fraud and corruption and how such risks will be mitigated. The assessment covered MoHSW, PMO-RALG and a sample of 8 regional administrations, 22 Local Government Authorities (LGAs) and 38 Health Facilities in line with Operational Policy/Bank Procedure (OP/BP) 9.00, Program-for-Results Financing. Teams visited a representative sample of regions, LGAs, health centers and dispensaries to collect this data. The assessment takes into consideration the BRN healthcare NKRA Lab report; Controller and Auditor General's Report for LGAs and Central Government for FY13; Tanzania PEFA reports for 2006, 2010 and 2013; Annual Performance Evaluation Report of the Public Procurement Regulatory Authority (PPRA); the Procurement and Value for Money Audit reports of selected LGAs and specific assessments done on MoHSW, PMO-RALG and MSD. The NKRA Lab report identifies some major challenges such as incomplete reporting by the HMIS, insufficient data analysis capacity, under funding of the health sector, procurement bottlenecks, supply chain challenges, corruption and favoritism in health facilities, poor adherence to guidelines, erosion of MSD working capital and weak inventory control among others. These will be addressed by streamlining and improving the supply chain process, ensuring governance accountability at all levels, performance targets and contracts, fiscal decentralization by devolution, strengthen financial management of MSD, improve governance and accountability, use ICT platform, reduction of pilferages, support funding for medicines, social accountability and implementation of star rating of health facilities.

2. The FSA covers institutional and implementation arrangements, fiduciary management capacity and implementation performance. The legal and regulatory framework for this Program's fiduciary systems was found to be comprehensive and in line with international principles and standards for public procurement and financial management. However, at the health facility level it was noted that there are no fiduciary systems in place as the facilities are not currently managing any financial and procurement activities. In that regard fiduciary systems' analysis was carried out at the LGAs and MDAs. The assessment also considered how existing systems handle the risks of fraud and corruption.

3. **Financial Management risk for the program is rated as substantial.** Key risks include timely transfer of funds from the treasury to the LGAs and health facilities, late submission of reports, weak audit committees at the LGAs, challenges of the Epicor system, chart of accounts not able to track funds by individual source as well as lack of FM systems and staff at the health facilities. Other risks include weak accounting and internal audit staff skills especially at the LGAs in order to produce quality reports, accounts and conduct quality audits. The following measures would need to be implemented to address shortcomings: strengthening audit committees in order to monitor how audit issues are being addressed; addressing the challenges faced by the Epicor system, revising the chart of accounts such that it can track funding from Development Partners; ensuring that discrepancies between funds transferred from treasury to LGAs and health facilities are eliminated through putting in place transparency measures such as displaying amounts transferred at both LGA and health facility levels; addressing the challenge of delays in receiving financial reports from the Health Facilities and LGAs which will be addressed through appointment of Ward accounting technicians and capacity building of the persons involved both at HFs and councils. Furthermore, there will be need to strengthen auditing arrangements for Health Facilities as it will be a challenge for the CAG to audit them given the large number of health facilities involved in the program. This will be mitigated by contracting out the audit to private external audit firms acceptable to IDA.

4. **Procurement risk is rated as substantial.** Main risks are inadequate staffing in LGAs; inadequate knowledge of PPA 2011 and its Regulations, planning, bidding documents & request for proposals preparation and evaluation of bids/proposals; inefficiencies in managing procurement processes; delays in vetting contracts above Tshs 50,000,000 by the AG; weak records keeping and management system; weak contract management—The following mitigation measures need to be considered both before as well as during program implementation to

address the risk: recruit/appoint qualified and experienced staff to fill the gap; conduct tailored trainings on PPA 2011 and its Regulations to PMUs and internal audit units; establish sound records management system in all LGAs and participating MDAs; ensure procurements are processed as per the timelines in the procurement plan and responsible organs play their roles as stipulated by PPA; ensure LGAs abide with all procedures for processing quotations including publications of contracts awards as per the PPA; review to uplift vetting thresholds; and conduct tailor made trainings on contract management.

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

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

2 Background and the Program Institutional Arrangements

2.1 Program Description

7. This PforR operation will support the Government’s primary health care (PHC) program for the 2015/16 – 2019/20.

8. PHC under the Health Sector Strategic Plan IV 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.

Big Results Now in Health

9. 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:

- (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) fiscal decentralization at the facility level, (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 CEmONC to selected

hospitals and health centers, (iii) strengthening the corresponding satellite blood banks which serve facilities with Comprehensive Emergency Obstetric and Neonatal Care (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.

2.2 Institutional Framework and Implementation Arrangements

2.2.1 Legal Framework for Public Financial Management

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

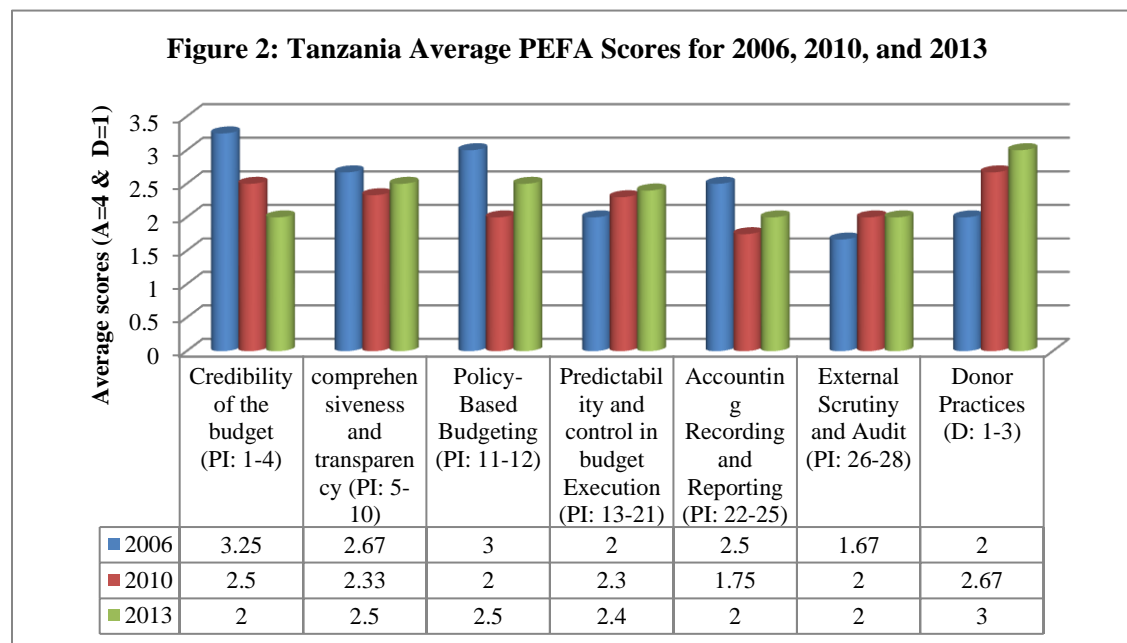
Table 2: PFM related legislation in Tanzania

Area	Description
Budget preparation, execution, reporting & accounting.	<ul style="list-style-type: none"> Public Finance Act 2001 amended 2004 & 2010. Public Procurement Act, 2004, amended 2011
Decentralization	Local Government Finance Act 1982.
External Audit	Public Audit Act 2008, amended 2011
Legislative Oversight	The Constitution and the Standing Orders of the National Assembly.

Source: Government of Tanzania 2013 PEFA Report.

2.2.2 Financial Management

8. **The Government of Tanzania has undertaken a number of Public Financial Management (PFM) reforms and is now in its fourth PFM Reform Program which commenced on July 1, 2012.** However, the Public Expenditure and Financial Accountability (PEFA)¹ Performance Indicators for Tanzania for 2006, 2010, and 2013 show mixed results as shown in Figure 2 below.



¹ PEFA is a global partnership of bilateral and multilateral donors including the World Bank formed to assess the condition of countries' public expenditure, procurement, and financial accountability systems and to develop a Practical sequence of reform and capacity-building actions (<http://www.pefa.org/>).

9. These findings show improvements in predictability and control in budget execution since 2006 although a lot more remains to be done in relation to the effectiveness of internal controls for non-salary expenditures (PI² 20). There are also improvements since 2010 in policy based budgeting and accounting, recording and reporting although the timeliness and regularity of accounts reconciliations (PI 22) needs to improve. External scrutiny and audit has not improved since 2010. There are concerns about the credibility of the budget whose performance has been declining since 2006 mainly because of the composition of expenditure out-turn compared to original approved budget (PI 2) arising out of cash rationing due to resource uncertainty, commitment controls being bypassed and insufficient access to excess liquidity in GoT bank accounts held in commercial banks. As a result, expenditure arrears have accumulated and they are paid out of budgets in the following years at the expense of planned service delivery.

10. **The Legal and Regulatory Framework for this Program's procurement will be governed by the new Public Procurement Act of 2011 (PPA 2011) and attendant Regulations 2013.** Procurements at the Ministry of Health and Social Welfare (MoHSW), the Prime Minister Office Regional Administration and Local Governments (PMO-RALG), Medical Stores Department (MSD) and Local Government Authorities (LGAs) will follow the Public Procurement Act No.7 of 2011 and the associated Regulations of December 2013 as well as Regulations for Local Government Authorities (Establishment and Proceeding of Tender Boards) of 2007. Under the PPA 2011, the procurement functions remain decentralized to procuring entities while the Public Procurement Regulatory Authority (PPRA) continues to provide oversight functions. The PPA 2011 has strengthened some of the mandate of PPRA including the power to cancel procurement proceedings after conducting an investigation and being reasonably satisfied that there is a breach of the Act and its Regulations.

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

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

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

² PI stands for Performance Indicator.

3 Program Fiduciary Performance and Significant Fiduciary Risks

3.1 Financial Management Risk Consideration

3.1.1 Planning and Budgeting

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

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

3.1.2 Accounting and Financial Reporting

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

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

15. Given that this will be a large and complex program covering the whole country, there is a risk that there will be delays in submission of accurate financial reports given that there could be communication challenges between the Health Facilities and the LGAs. There will be a need to train staff in order to enhance their skills in planning and reporting. Also, PMO-RALG and MoHSW should jointly develop appropriate standardized reporting templates to capture FM data required for program monitoring.

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

3.1.3 Treasury Management and Funds Flow

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

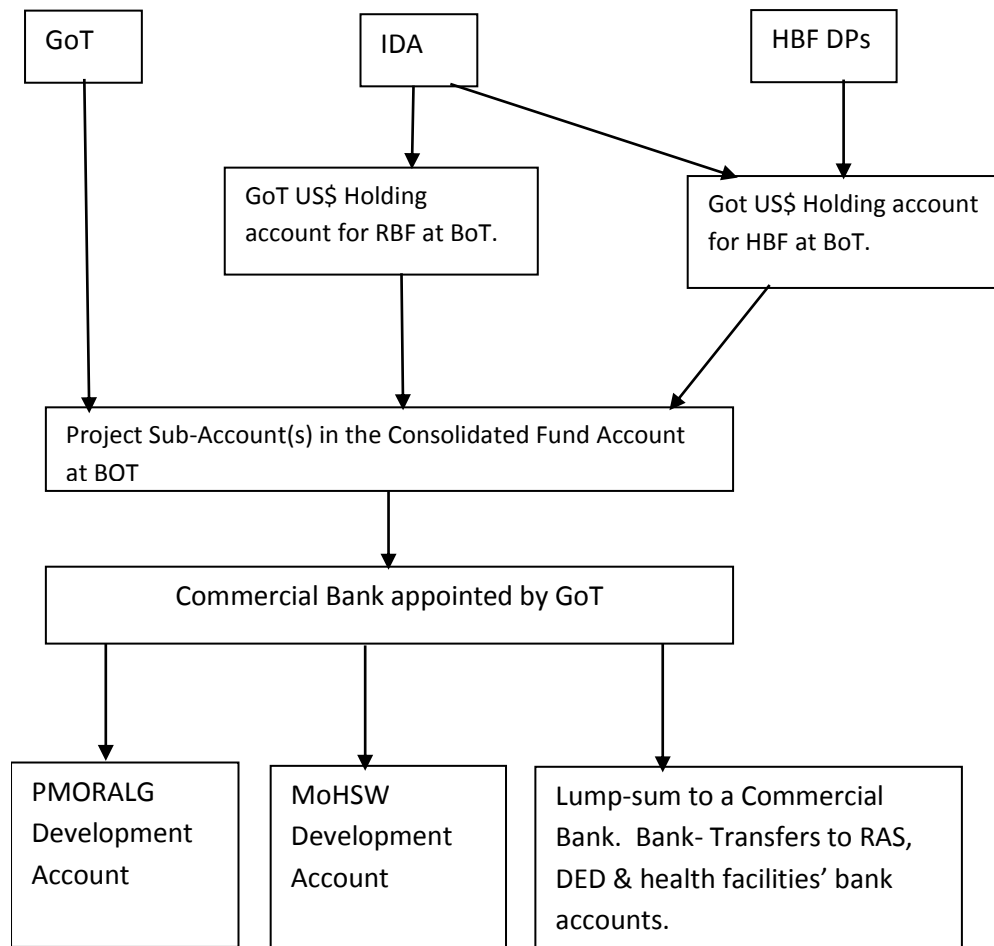
No Designated or Special accounts will be operated for this operation. Funds will flow from IDA into the government owned Holding Account for HBF and another for RBF both at BOT and denominated in United States Dollars. From there funds will be transferred to the Consolidated Fund sub-account for the program denominated in local currency also at the BoT. MoHSW, PMO-RALG, LGAs and health facilities will be paid through the Exchequer Issue Notification and transfers from the Consolidated Fund sub-account for the program will be made

directly to their bank accounts mainly held by commercial banks. Payments will then be made from these accounts. The details of the Holding Accounts for HBF and RBF as well as the Consolidated Fund sub-account at BoT and their signatories should be submitted to the Bank between the signing of the Credit and its effectiveness. The opening of bank accounts at MoHSW, PMO-RALG, LGAs and HFs should be in line with the existing government guidelines as issued by the Accountant General. The chart of accounts in Epicor will need to be expanded to incorporate individual facility bank accounts in order to capture funds transfers as revenue and payments as expenditure. This will make it easier for audit verification of program funded transactions.

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

18.

Figure 3: Funds Flow Diagram for BRNH

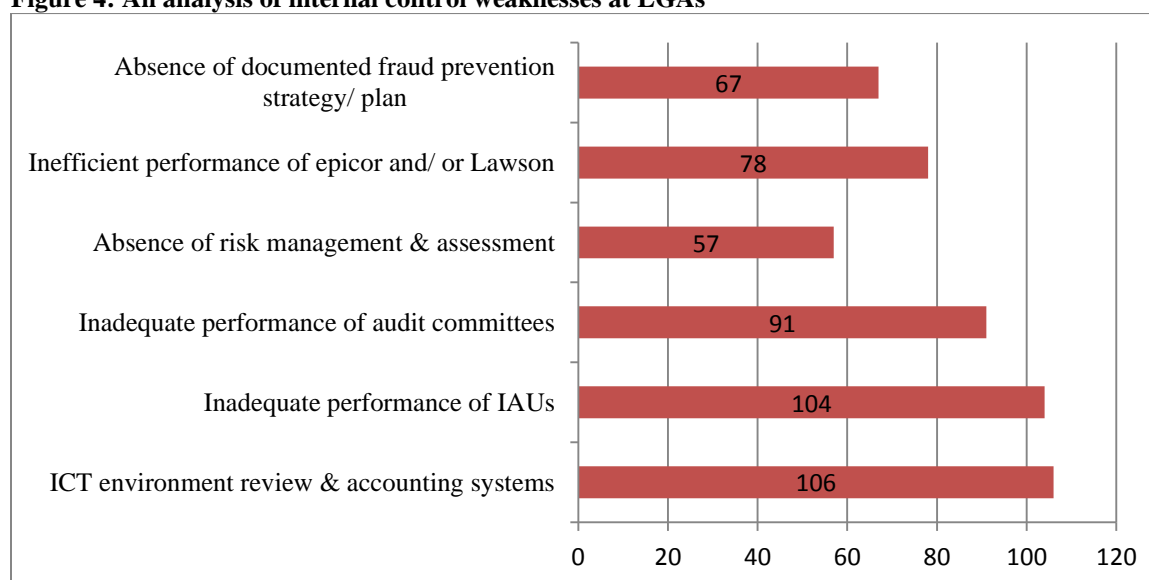


3.1.4 Internal Controls (including Internal Audit)

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

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

Figure 4: An analysis of internal control weaknesses at LGAs



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

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

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

3.1.5 External Audit

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

The Public Audit Act no. 11 of 2008 grants the Controller and Auditor General (CAG) sole responsibility for statutory audit of all MDAs and LGAs³. CAG discharges this responsibility either directly or through private auditors contracted as agents. Outsourcing of the audits partly solves the challenge of staff constraints at the CAG office. The CAG has regularly carried out external audits on time and issued reports within nine months of the year end, as stipulated under the law. However, the major risk is the CAG having challenges of auditing the large number of health facilities which can be addressed by outsourcing to private audit firms. The program will, however, need to budget for this. As noted in the PEFA indicators there are delays in the scrutiny of CAG's reports by relevant parliamentary committees that need to be improved on by building their capacity. Audit terms of reference should be agreed on an annual basis between CAG, MoHSW, PMO-RALG, LGAs and IDA to ensure there is an agreeable scope coverage given the risk of the program. Should there be need to conduct other forms of audit, e.g. forensic and value for money audits, these will be done by CAG that has departments handling these types of audit.

3.2 Procurement Risk Considerations

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

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

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

25. **Procurement Processes and Procedures.** The PPA and its associated Regulations require procuring entities wishing to commence competitive tendering to provide all eligible bidders with timely and adequate notification of the procuring entity's requirements and an equal opportunity to tender for the required goods, works or services. The Regulations spell out the contents of invitation to tender and it is mandatory that invitations to tender be made in writing. The format of advertisement used to publish the advertisement is issued by PPRA and it contains adequate information to the prospective bidders to make decision to participate. It is mandatory that the

³ Audit at LGAs is governed by the Local Government Finances Act No.9 of 1982 (revised 2000) which stipulates that accounts of every LGA shall be audited by the National Audit Office (NAO)

solicitation documents be issued immediately after first publication of the tender notice to all bidders who respond to the tender notice. Under PPA 2011, it is mandatory for procuring entities to prepare a tender notice for national and international tenders and submit the same to PPRA for publication in the Journal and Tenders Portal.

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

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

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

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

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

31. Transparency is among the fundamental pillars of public procurement and disclosure of information is one of the elements of transparency. On average in about 40% of the tenders awarded, unsuccessful bidders were not informed on the award decisions and publications of awards were not published on LGA's notice board or availed to PPRA. The law requires PPRA to publish contracts awarded in its Journal and Tender Portal, the names of those who have been awarded the contracts, contract amount, the date when the awards were made, contracts period and

final contracts amount. For PPRA to fulfill this requirement procuring entities are required to notify PPRA on the awarded contracts for further publishing. However, from PPRA's audit reports the compliance on the publication of contract awards still a problem.

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

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

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

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

36. **Records Keeping.** The PPA and its Regulations prescribe procurement records that should be maintained and archived by a procuring entity; these include procurement proceedings and decisions taken and the reasons for those decisions. The records range from planning to contract closure and to be kept for five years after contract closure. Generally, records in the LGAs are scattered, incomplete, with no proper filing and management system. PMUs are maintaining and archiving records of tendering process while account departments are maintaining payments records, and user departments are maintaining and archiving contract management records with consequent difficulties to trace records of particular tender in one file. There is inadequate space for PMU staff and documents storage.

37. Procurement arrangements of medicines and medical supplies at the facility levels: In principle, no procurement of medicine is undertaken at the facility level. MSD is charged with responsibility of procuring medicines and medical suppliers and distributing directly to government hospitals including accredited private referral hospitals/facility, district hospitals, health centers and dispensaries. LGAs undertake procurement of medicines and medical supplies only when they receive the non-availability notice from MSD and procure using the funds allocated in their budget. In this case, after receiving such notice, facilities channel their requirements to DMO who consolidates all requirements including district hospitals' requirements prior forwarding the same to the District Executive Director (DED) for sanction and subsequent submission to PMU for processing. PMUs are responsible for managing all procurement of medicines and medical supplies. During the assessment, it was noted that the

procurement of medicines and medical supplies from the private vendors were procured through competitive quotations as a default method from the pre-qualified suppliers.

3.2.1 Fraud and Corruption Analysis

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

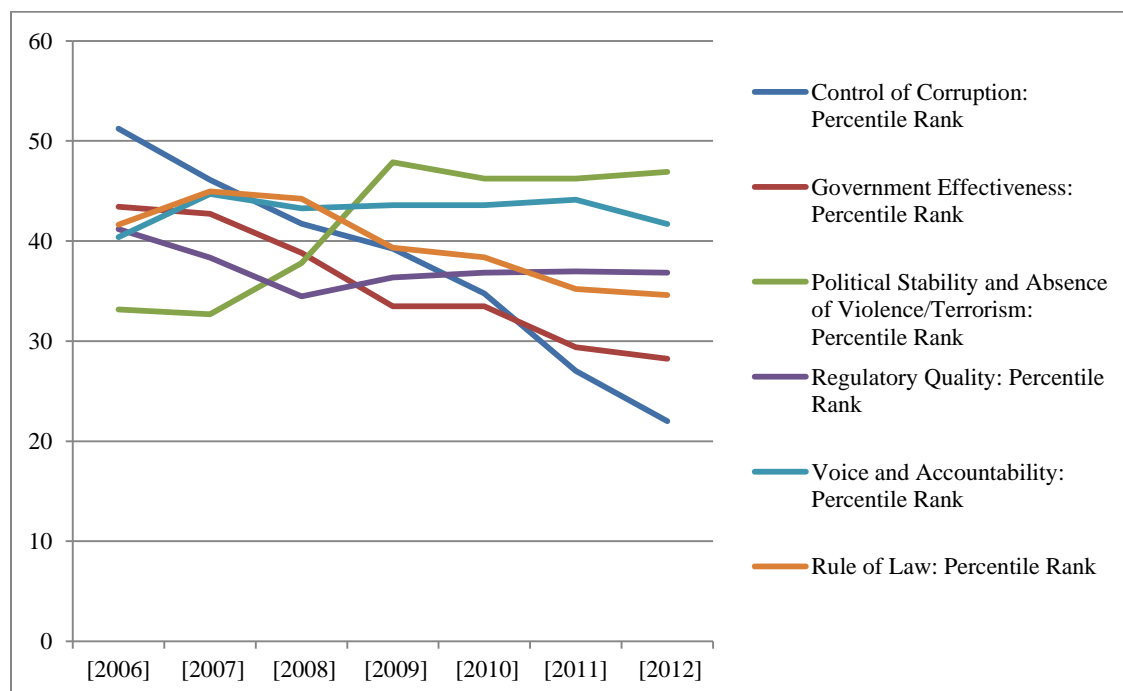
Table 5: Analysis of allegations received and cases investigated

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

*Jan to June 2015

Source: PCCB Head office, September 2014

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



3.2.2 Fraud and Corruption Risks for this PforR

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

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

Facility Boards/Committees

Each health facility is governed by a board or committee that is responsible for providing oversight of the health services provided. The functionality of this board/committee is often poor with meetings that are supposed to be held quarterly rarely taking place and records not kept or shared with the District management. The members of the board/committee are also poorly informed about their role. Strengthening the functioning of facility boards/committees is essential in improving accountability for service delivery at the facility level. In addition, the boards/committees need adequate information on budgets, staffing and other service delivery inputs to be able to carry out their oversight role effectively. This will help to ensure that the facilities performance is reported to the community representatives, District management is able to track the facilities performance and hence make supervisory visits more meaningful. Overall, well-functioning facility boards/committees should be able to raise concerns on the quality of services to management and to ensure they are addressed.

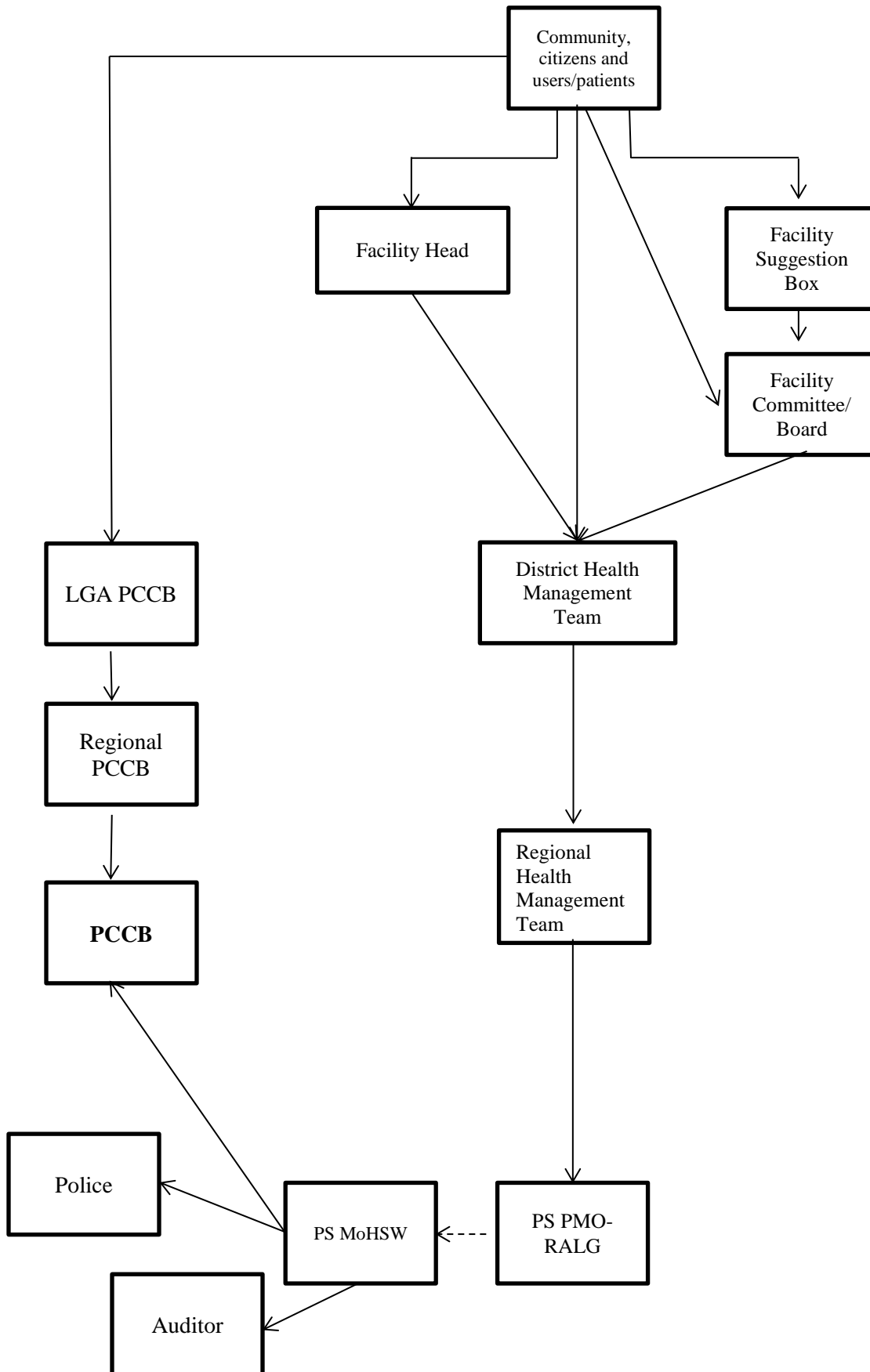
Complaint Handling Mechanisms

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

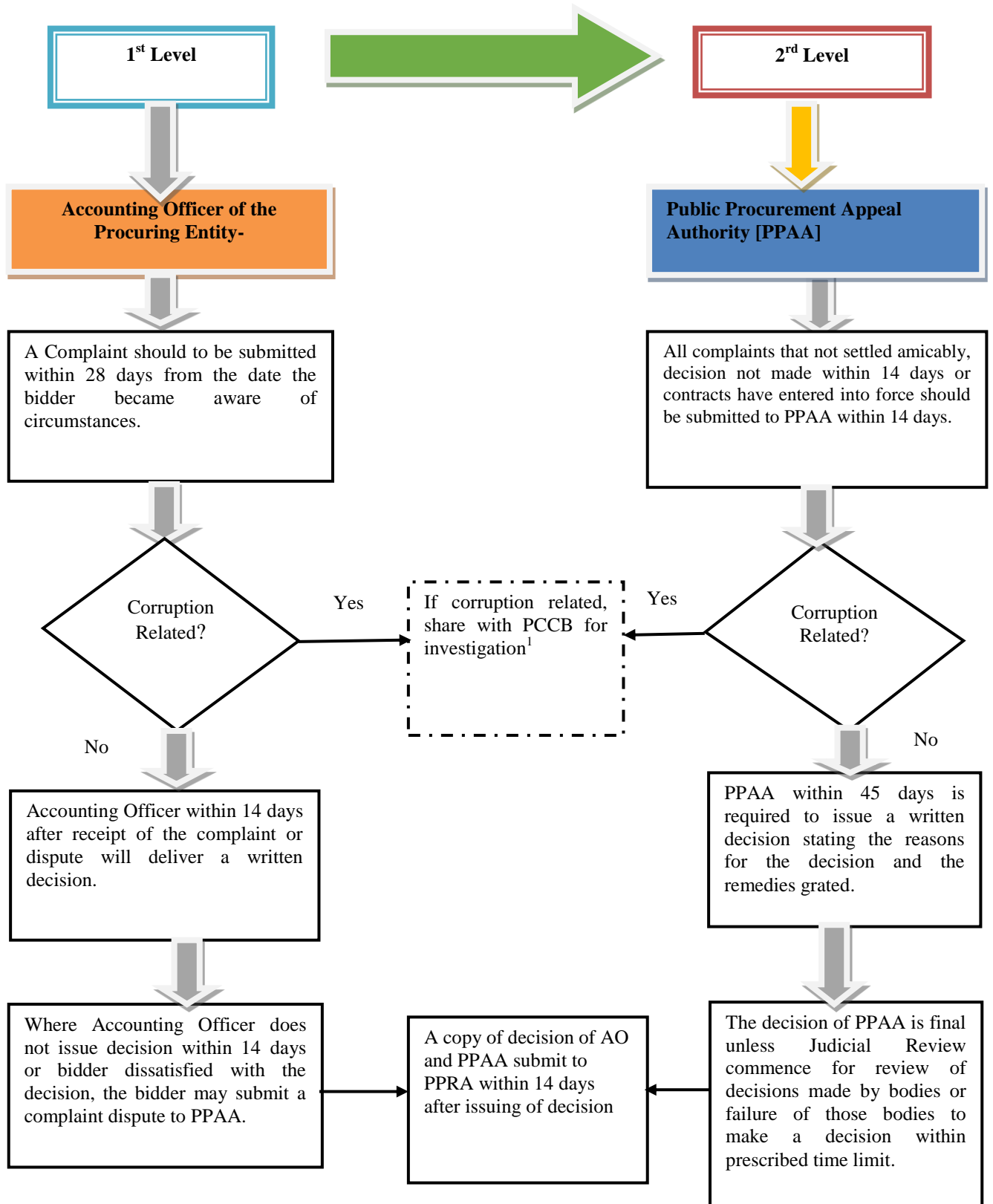
For the purpose of this PforR, the existing CHM mechanisms will be strengthened. The objective should be to strengthen the oversight committees at the level of the health center and hospitals to ensure that they provide appropriate oversight of the health service including ensuring a functioning CHM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

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

Flow Chart 1: Complaint Handling Mechanisms



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



3.2.3 Alignment with Anti-Corruption Guidelines for PforR Operations

3.2.3.1 Sharing of Debarment list of firms and individuals

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

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

3.2.3.2 Sharing information on fraud and corruption allegations

In line with the ACGs, the government (through MoHSW) will share with the Bank all information on fraud and corruption allegations, investigations and actions taken on the Program, including on procurement as needed. The Bank has been informed that under Tanzania's legal system, the primary agency for investigating corruption is the Prevention and Combating of Corruption Bureau (PCCB). Where PCCB investigations reveal that a given case is primarily one of fraud rather than corruption, the PCCB refers it to the police for further investigation and prosecution. In this context, fraud and corruption allegations made in respect of Program funds will be referred by the beneficiaries to the district offices of the PCCB. The PCCB gets monthly reports from the Regional Offices on fraud and corruption and other relevant activities, but in the case of this program, the PCCB would compile and share information on fraud and corruption once every 6 months to MoHSW who will share with the Bank. The details of this reporting would include the types of allegations and the status of actions taken. A template for recording and sharing the information with the Bank has been provided to the PCCB.

3.2.3.3 Investigations of fraud and corruption allegations

The GoT has advised that (i) the Prevention and Combating of Corruption Act permits the PCCB to cooperate and collaborate with the Bank in the fight against corruption, and permits the PCCB and the Bank to undertake joint investigations of sanctionable practices if and when the parties so agree; (ii) the Bank may also undertake its own investigations of F&C allegations under the Program. In this context, the investigation of F&C allegations under the Program will be handled through three possible modalities, depending on circumstances: (i) the PCCB will undertake its own independent corruption investigations arising from allegations reported to it as detailed above; (ii) the PCCB and INT will undertake joint corruption investigations. The initiation, scope and operational procedures will be decided on a case-by-case basis by PCCB and INT; and (iii) INT will undertake its own F&C investigations. To this extent, the Program Participation Agreements to be entered into between MoHSW and PMO-RALG will ensure that both entities and INT are able to acquire all records and documentation that they may reasonably request from the Program implementation Units regarding the use of Program funding.

4 Fiduciary Risk and Mitigation Measures

Integrated Fiduciary Risk and Mitigation Measures

Fiduciary Risk	Description	Mitigation Measures	Due Date	Responsibility
<i>Program Level</i>	Coordination due to the large number of entities involved. Ensuring funds are used for purposes intended will be a challenge.	Appoint Sector Technical and Program Steering Committees to provide oversight in ensuring smooth program coordination at all levels. Establish a Program Coordination Unit that includes members from PMO-RALG which will be responsible for providing overall supervision.	Completed	MoHSW and PMORALG

Fiduciary Risk	Description	Mitigation Measures	Due Date	Responsibility
	Weak fiduciary capacity in all fiduciary aspects highlighted below	Provide targeted capacity building to all fiduciary staff at all levels.	Within 12 months of project implementation	
Financial Management Risk				
Planning and Budgeting	Unfunded budgets Absence of reliable cash-flows affecting implementation of planned activities	Earmark SPHCR funds using accounting codes at the Consolidated Fund using a sub-account for the project under MoHSW.	Within 12 months of project implementation.	MoHSW, MoF and PMO-RALG
	PlanRep may not automatically upload the budget to Epicor requiring it to be manually done which is subject to errors and delays.	Prepare reliable cash flow budgets.	Quarterly.	
		Acquire and install an integrator to link the PlanReP and Epicor for automatic uploading of budgets onto Epicor.	Within 12 months of project implementation	
Accounting and Financial Reporting	Funds not being used for purpose intended	Put in place FM systems and guidelines at HCF level. Appoint and train Ward Accounts Technicians who will be responsible for FM at the facility level	Within 12 months of project implementation	MoHSW, PMO-RALG and MoF
	The chart of accounts may not show which Development Partner is funding the program when funds are sent to the LGA hence not able to prepare accountability for a Development Partner's funding.	Revise the chart of accounts.	Within 12 months of project implementation.	
	Poor connectivity between the LGAs and the central servers.	Strengthen the connectivity in Epicor in order to efficiently use the system.		
	Failure to record assets at all levels.	Activate the asset management module.	Within 12 months of project implementation	
	Epicor 9.05 not able to generate annual financial statement and management reports.	Enhance financial reporting module for Epicor in order to produce useful reports for management to take action.	Within 12 months of project implementation	

Fiduciary Risk	Description	Mitigation Measures	Due Date	Responsibility
	Delays in submission of various financial reports.	Train staff who consistently send reports late to enhance their skills as well as closely monitor them at both health facility and LGA levels to ensure timely financial reports are received.	Annually	
	Absence of book-keeping skills at HCF is going to impact maintenance of reliable financial records.	Hire ward-level (or similar group) accounting technicians to assist HCFs on an-ongoing basis to supplement limited capacity of LGAs.	Within 12 months of project implementation	
Treasury Management and Funds Flow	Not all HCFs will have bank accounts	Bank accounts are opened by all HCFs before funds are disbursed.	Before funds are disbursed to HCFs	MoF, MoHSW, PMO-RALG, LGAs & HCFs
	Delays in release of funds from MoF to ministries, LGAs and HCFs.	Monitor the budget approval process and endorsement by the Parliament now tabled in April to June each year. Timely disbursement will also be monitored and concerns will be brought to the attention of MoF in a timely manner.	Annually	
	Irregular release of funds by the Ministry of Finance to LGAs and HCFs.	Request GoT commitment to ensure release of funds to Program on a quarterly basis.		
	Delayed release of funds from LGAs to HCFs.	LGAs & HCFs to display amounts transferred to them on their notice boards and their websites. Delays will also be monitored and delays brought to the attention of LGAs.		
	Funds may not be used efficiently and effectively to achieve the purposes for which intended	Carry out value for money audits	Midterm and end of program	
Internal Controls (including Internal Audit)	Non-compliance with internal control systems at both central and local government levels.	Skills of audit committees and internal auditors will be enhanced to effectively monitor compliance of the internal control systems and report on a quarterly basis.	Within 12 months of project implementation	MoHSW, PMO-RALG, MoF and LGAs.
	Weak internal audit function in terms of skills, equipment, lack of access to Epicor system and budget to monitor the internal controls put in place.	Strengthen internal audit units through training and capacity building. Facilitate internal audit units with resources to conduct their operations. Production of quarterly audit reports. Grant internal auditors access to Epicor as well as acquisition of internal audit software.	Within 12 months of project implementation and annually thereafter	

Fiduciary Risk	Description	Mitigation Measures	Due Date	Responsibility
External Audit	Failure to audit a reasonable sample of HCFs given the large number of HCFs supported under the Program.	CAG to contract private audit firms to conduct audits on his behalf.	Before end of FY	CAG, MoHSW, PMO-RALG.
	Delayed submission of reports	Early appointment of auditors and agreeing of ToRs. Carrying out of interim audits.		
	Slow scrutiny of CAGs audit reports by the PAC and LAAC which affects the accountability process.	Enhance technical skills of PAC and LAAC in order for them to improve on their efficiency in following up issues raised by CAG's audit reports.		
Procurement Risks				
Procurement Capacity and internal audit function	Inadequate staffing in LGA procurement and internal audit units as well as existing staff have inadequate knowledge of PPA 2011 and its Regulations	Recruit/appoint qualified and experienced staff to fill the gap in the two units and conduct tailored trainings on PPA 2011 and its Regulations and contract management to PMUs and internal audit units	Within 12 months of project implementation	PMO-RALG & PPRA
Records keeping	Weak records management system.	Establish sound records management system in all LGAs and participating MDAs.	Within six months of project implementation	PMO-RALG/LGAs
Procurement Efficiency	Inefficiencies in processing and managing procurement activities.	Ensure procurements are processed as per the timelines in the procurement plans	Throughout project implementation	PMO-RALG, LGAs
Transparency in procurement process	Lack of transparency in processing competitive quotations and publications of contract awards.	Ensure LGAs abides with all procedures for processing quotations including publications of contracts awards as per the PPA.	Throughout project implementation	PMO-RALG, LGAs and PPRA
Delays arising from vetting of contracts before signature	The AG has no capacity to vet all contracts above TZS 50 million within 21 days prescribed under PPA.	Review the existing threshold with a view to uplift vetting thresholds.	Within 12 months of the project implementation	PMO-RALG, AG and PPRA
Weak Contract Management	Inadequate knowledge and skills in contract managements.	Conduct trainings tailored to address the weakness to in the contract management.	Within 12 months of project implementation and annually thereafter	PMO-RALG, LGAs
Delays in issuing out stock notice to the facilities by MSD	Delays in issuing stock-out notice to the facilities by MSD in order for LGAs to commence procurement process of missing medicines and medical supplies in a timely manner	Establish the system that will ensure out stock notices are issued within one day as prescribed in the PPA 2011 and its Regulations.	Within one year of project implementation	MSD and MoHSW
Fraud and Corruption Risks				
Transparency	A lack of citizen, media and suppliers pressure to eliminate collusive practices due to lack of information.	Publish Clients Service Charters; strengthen government websites to publish timely reports, budget, including quarterly disbursement and	Within 12 months of project implementation and annually thereafter	MoHSW, PMO-RALG, LGAs and Health Facilities

Fiduciary Risk	Description	Mitigation Measures	Due Date	Responsibility
		execution reports; LGAs and Health Facilities to publish budgets and expenditures in public places. CHMT to provide budget and expenditure data to health facilities to enable them to improve performance.		
Participation	Weak use of feedback and complaints handling mechanisms by stakeholders.	Implement mechanisms or partnerships with civil society organizations to enable citizen to log complaints or register comments and receive responses from central government/Ensure information on SPHCR is easily available to citizens to enable monitoring and feedback.	Within 12 months of project implementation and annually thereafter	MoHSW and PMO-RALG
Accountability	Weak response from central government and LGAs to citizen complaints and to poor performance on assessment reports.	Strengthen CHMT and Health Facilities service boards; review complaints register and ensure complaints are attended and feedback taken is adequately documented, responded to and posted to MoHSW & PMO-RALG website twice annually. Nominate Complaint Desk Officers at health facility level and for CHMT dedicated exclusively to health concerns.	Within 12 months of project implementation and annually thereafter	MoHSW, PMO-RALG, LGAs and Health Facilities

4.1 Overall Fiduciary Risk Rating

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

5 Financial Covenants

41. In order to strengthen fiduciary systems, the following Financial Covenants are proposed in addition to the usual standard covenants:
- Appointment of Ward Accounting Technicians to provide FM support to the HFs.
 - Conducting annual independent procurement audits of the program.
 - Conducting a value for money audit during the mid-term and end of the program.

6 Implementation Support Plan

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