



---

# Project Information Document/ Integrated Safeguards Data Sheet (PID/ISDS)

---

Concept Stage | Date Prepared/Updated: 14-Nov-2017 | Report No: PIDISDSC23199



**BASIC INFORMATION**

**A. Basic Project Data**

Country Tanzania	Project ID P164758	Parent Project ID (if any)	Project Name Investing in the Early Years (P164758)
Region AFRICA	Estimated Appraisal Date Jul 31, 2018	Estimated Board Date Nov 30, 2018	Practice Area (Lead) Health, Nutrition & Population
Financing Instrument Investment Project Financing	Borrower(s) Ministry of Finance and Planning	Implementing Agency President's Office Regional Administration and Local Government, Ministry of Health, Community Development, Gender, Elderly and Children	

**Proposed Development Objective(s)**

Improve coverage and quality of the early childhood development services for the first 1,000 days in selected regions.

**Financing (in USD Million)**

**SUMMARY**

<b>Total Project Cost</b>	200.00
<b>Total Financing</b>	200.00
<b>Financing Gap</b>	0.00

**DETAILS**

<b>Total World Bank Group Financing</b>	200.00
World Bank Lending	200.00

Environmental Assessment Category  
B-Partial Assessment

Concept Review Decision  
Track II-The review did authorize the preparation to continue



## B. Introduction and Context

### Country Context

1. **Tanzania has maintained a relatively high level of political and economic stability.** Since independence in the early 1960s, Tanzania has seen a continuing trend of peaceful and democratic transition with regular elections. Its annual gross domestic product growth rate was over seven percent from 2013 to 2016 (World Bank 2017a). The inflation rate has also remained moderate at about five to seven percent in recently years even with drought leading to an increase in food prices in some regions and rising energy costs (IMF 2017). The economy also continues to adjust to government policies and public administration reforms including tighter fiscal controls and improving accountability of public institutions (World Bank 2017b).

2. **Despite relatively strong and stable economic growth, the poverty rate remains high, there is a high population growth rate, and human development progress is sub-optimal.** The poverty rate based on the national poverty line declined from 34 percent in 2007 to 28 percent in 2011/12 and extreme poverty from 12 percent to 10 percent during the same period. However, with the high level of population growth, about 11.9 million people live in poverty and 4.2 million in extreme poverty (World Bank 2015). Also, a significant proportion of Tanzanians live on the edge of poverty and are thus at risk of slipping below the poverty line in case of economic shocks. In addition, the poverty rate varies considerably by geographical area: four percent in Dar es Salaam in 2011/12 and 33 percent in rural areas, where over 70 percent of the population lives. According to the World Population Prospects 2017, Tanzania's population growth rate remains at about three percent due to a persistently high fertility rate (5.2 births per women). At the current growth rate, the population is projected to double from about 55.5 million in 2016 to over 100 million by 2037 (UN Population Division 2017). Human Development Index (HDI) value improved from 0.446 in 2005 to 0.531 in 2015, but Tanzania remained in the low human development category (151th out of 188 countries). When the value was discounted for inequality, the HDI fell to 0.396.

### Sectoral and Institutional Context

3. **Early childhood care and experiences, especially in the first 1,000 days, have a profound impact on early childhood development (ECD), having longer term effects on learning, health, nutrition, and ultimately income.** And yet millions of young children are not reaching their full potential because of a complex interplay of inadequate nutrition and health, lack of early stimulation and learning, and exposure to stress that adversely affect their development. To ensure that children gain physical, social and emotional capacities to learn, earn, innovate and compete, it is critical to seize the very narrow window of opportunity to support the child's brain and physical development. Nearly 90 percent of a child's brain development occurs from conception to the age of five and 80 percent before age three (Grantham-McGregor et al. 2007). Likewise, growth faltering often begins in utero and continues for the first two years of life (Shrimpton et al. 2001). Consequences of children failing to reach their developmental potential are life-long and have multitude of effects including cognitive function, health, human capital, income, and equity. Evidence shows that the earlier a child becomes affected (e.g., stunted), the greater the long-term consequences are and thus a critical need for investing in ECD (Allen & Gillespie 2015).

4. **In Tanzania, despite substantial gains made in child survival and some improvement in nutrition status over the last 10 years, serious challenges for ECD remain.** The under-five mortality rate has nearly halved between 2004/5 and 2015/16 from 112 to 67 per 1,000 live births. The country has also reduced stunting prevalence by 10 percentage



points (from 44 to 34 percent) during the same period largely thanks to increased vaccination and use of mosquito nets, safe disposal of stools and increased skilled delivery. However, stunting is still unacceptably high, affecting more than one in three children under five in Tanzania. Micronutrient deficiencies among women of reproductive age and children are also high, leading to poor health and other child development outcomes. There is clear evidence of an intergenerational cycle of undernutrition with about seven percent of children born with low birth weight. In Tanzania, there is no measurement of overall child development outcomes for children under three, including socio-emotional and cognitive development. Given the association between stunting and cognitive function, stunting could be used as a proxy for cognitive development. While students in Standard One performed relatively well overall in pre-numeracy (59 percent), they tended to struggle with more cognitively engaging tasks such as mental transformation (28 percent). Overall, students were weakest in literacy and communication abilities, socio-emotional abilities and executive function (World Bank 2017c).

5. **ECD outcomes such as adequate nutrition, cognitive and socio-emotional development vary dramatically by region and by socio-economic status.** Six regions still have stunting rates greater than 40 percent. Among households in the poorest three quintiles, two in five children are also stunted, and the rates of improvement have been slower in this group. Even in the wealthiest quintile, a fifth of children are stunted, showing that undernutrition is not only due to low income or food insecurity. Children enrolled in Standard One in rural areas score an average of 40 percent for both executive functioning and socio-emotional development, compared with 43 percent and 57 percent, respectively for their urban counterparts (World Bank 2017c).

6. **Multiple factors including inadequate water, sanitation, and hygiene (WASH), along with poor reproductive, maternal, adolescent and child health and care contribute to the poor ECD outcomes including stunting.** Several studies have identified factors contributing to the high levels of stunting in Tanzania such as inadequate water and sanitation, fetal growth restriction/low birth weight, and childhood infections. Thus, a multi-sectoral approach, involving nutrition-specific as well as nutrition-sensitive interventions that aim to influence these risk factors, is required to accelerate improvements in nutrition status and ensure optimal child development. The weight of international research including those in Tanzania further indicates that holistic ECD programs that enhance not only nutrition, but also health and early stimulation are more likely to support children reaching their full developmental potential and generate long-lasting impacts than one of these alone. Thus, it is recommended that parenting and caregiver education for early stimulation is, for example, purposely incorporated into the existing nutrition and health outreach programs in Tanzania.

7. **While much is known about high impact cost efficient ECD interventions, coverage remains generally low and varies widely by socio-economic factors.** While three quarters of children receive essential child health care services like immunization, complementary feeding is inappropriate in general with less than 10 percent of the children 6-23 months having received adequate complementary feeding in terms of frequency and diversity; 16 percent of children from the wealthiest 20 percent households received adequate complementary feeding compared to only six percent among those from the bottom 20 percent. Coverage of WASH interventions can also be expanded as currently less than one out of five households have access to improved/non-shared toilet facilities. Despite substantial government efforts, pre-primary school enrollment (net) remains low at 46 percent in 2016, while primary school enrollment (net) was 86 percent in 2016 (Ministry of Education, Science and Technology 2016). The Government of Tanzania (GOT) does not currently provide early stimulation programs for children under the age of three. While early stimulation and promotion of parental engagement with young children is offered on a small-scale by a variety of non-state



organizations in Tanzania, this is not done systematically and there are no accurate figures on coverage of any of these services.

8. **Access to and utilization of these interventions as well as pro-ECD behavior changes are constrained by both supply and demand side barriers.** Community-based interventions that can promote positive-ECD knowledge and behaviors as well as increase demand for essential services are critical to any ECD program, but there is no platform to deliver such interventions nationwide. In addition, the budget allocation for the preventive and promotive services that are known to improve ECD outcomes are inadequate. For example, the share of health in the budget has remained at about nine percent and that of nutrition continued to be minimal at less than 0.25 percent in 2012/2013 (Ministry of Finance 2014). Thus, coverage of high impact (mostly preventive and promotive) interventions at the facility, community, household levels is low in general and varies widely by region depending on the presence and support provided by development partners (DPs) to fill the immediate gaps. For instance, about half of the regions have both critical levels of stunting (e.g. over 30 percent) and low coverage of key nutrition actions such as counseling on complementary feeding, education on hygiene and cash transfer for the vulnerable. Health professionals and community volunteers have limited training in nutrition and therefore are unable to encourage necessary behavior changes essential to improving nutrition outcomes. One quarter of preschool teachers are also unqualified and teachers are not receiving sufficient training to teach young children effectively even though the GOT has a strong new curriculum for pre-primary education which reflects developmentally appropriate practice (MOEST 2016; World Bank 2017c). In addition, convergence of multi-sectoral efforts - e.g., health, nutrition, WASH, early stimulation, social protection - is suboptimal even though the integrated services can generate better ECD outcomes.

9. **On the demand side, socio-cultural beliefs and practices, limited knowledge, low status of women, financial constraints, and long distance to facilities all impede demand for essential services and behavior change that lead to favorable ECD outcomes.** For example, two out of three women (66 percent) reported problems in accessing health care due to difficulty getting permission to go, trouble getting money for treatment, and/or long distance to health facility (TDHS 2015/16). Limited knowledge and/or harmful beliefs of caregivers and communities on how to care for women and children also negatively affect the ECD outcomes. For example, to minimize the effects of diarrhea on nutritional status, children with diarrhea are supposed to receive normal feeding and an increased amount of fluid. However, only half of Tanzanian children with diarrhea were fed the same amount as usual or more food, and only one in five children with diarrhea were given more liquids than usual. In some areas, traditions restrict pregnant women from eating or drinking certain foods in an effort to limit fetal growth and thus avoid complications during home delivery (Lennox et al. 2017). In addition, the majority of caregivers in rural Tanzania did not speak to their infant for the first six months, believing it was unnecessary as the infant was too young (Children in Crossfire 2015).

10. **In recent years, the GOT has shown strong political commitment to ECD and extended support to create an enabling environment, however there is still room for improvement.** The government has signaled its commitment to expanding early learning opportunities in several policy documents, including the government's Five Year Development Plan II (FYDP II) 2016-2021, the Education and Training Policy 2014, and the Education Sector Development Plan 2016-2020. While an ECD policy was drafted in 2010, it has not been formally approved. Also, the infrequency of meetings and lack of progress to pass the ECD policy and develop an implementation plan suggest that the entity in charge of ECD may not have the human, material, and financial resources necessary to fulfill its mandate and serve as a strong institutional anchor. Also, the Multi-sectoral Steering Committee on Nutrition is available at all levels, yet no such coordination mechanisms are in place for the overall ECD.



11. **The GOT recently launched the National Multisectoral Nutrition Action Plan (NMNAP) 2016-2021, indicating its commitment to addressing the high levels of malnutrition.** This costed action plan is to scale-up both nutrition specific and sensitive interventions in the key result areas of the NMNAP. It complements the 2016 Food and Nutrition Policy, within the FYDP II. At the 4<sup>th</sup> Joint Multi-Sectoral Nutrition Review in September 2017, the Prime Minister expressed his commitment to lead the event every year to review the progress toward achieving NMNAP objectives, and the Minister for Finance and Planning committed to additional budget (Tsh 11 billion). Nevertheless, much of the required resources have not been made available by the GOT or DPs, thereby affecting the government's ability to sufficiently implement the actions in the NMNAP. Also, the data systems pertaining to nutrition specific and sensitive programs, which draw on data from multiple sources and from multiple sectors, are not well consolidated. This limits policy makers and program managers' ability to analyze and use quality data to make informed decisions, and thereby affecting GOT response at all levels of the system.

12. **The GOT has established a new community platform as a modality to deliver community based health and social welfare services in the context of decentralization, but it has not been rolled out yet.** Tanzania has adapted various community participation and empowerment strategies to promote self-reliance and take local ownership of services. There are various cadres of officers and volunteers available in the ECD relevant sectors to provide services that can improve demand for essential services and positively influence ECD knowledge, attitudes and behaviors. However, most of these cadres have limited numbers, capacity (with no/little training), and financial/material resources to effectively provide ECD services. For example, nutrition officers and community development officers are only available at the Local Government Authority (LGA) level. Agriculture extension workers have other mandates, limiting their time to provide all the services that are essential to achieving the ECD outcomes. Thus, the government and DP funded programs have often engaged volunteers to deliver targeted services, but sustainability becomes an issue when funding ends. Under the Community Based Health Program (CBHP) established in 2014, the government plans to deploy two salaried community health workers (CHWs) per village (in total 30,000 CHWs) by 2025 to provide high impact interventions including nutrition, hygiene/sanitation, social welfare and child protection, at/close to the community level. So far, about 8,000 CHWs have been trained or are currently in training. With the strong commitment of the government, the CBHP has the potential to be a nationwide community-based platform that can deliver ECD services effectively; however, the government has not recruited (partly due to the hiring freeze issued in 2015 and lifted in 2017) or secured the funding to recruit CHWs and deploy them to the communities in the next few years.

#### Relationship to CPF

13. **The proposed project is aligned to the Tanzania Country Partnership Framework (CPF) (FY18 – FY22) currently being prepared.** The CPF has three strategic focus areas and 16 objectives. The proposed operation directly relates to Focus Area 2: Boost Human Capital and Social Inclusion – a Lifecycle Approach to Tanzania's Human Development Challenges, and specifically to Objective 2.1 – Investing in Early Years (IEY); a multi-sectoral effort to help children reach their full potential. Efforts in support of the early years' agenda will be intensified during the CPF period through on-going Bank-supported operations in the health, education, agriculture, social protection and WASH sectors, but also through this IEY operation focused on the critical 1,000-day window of opportunity that will build on and enhance coordination among and synergies with the on-going and pipeline operations to achieve the desired results effectively and efficiently.



14. **The proposed project will also contribute to the CPF's Focus Area 1: Enhance Productivity and Accelerate Diversified and Equitable Growth, through investments that generate healthier and more capable and productive adults.** Furthermore, Tanzania is a priority country under the World Bank's "IEY" corporate agenda; the proposed operation is a key contribution to the agenda.

15. **The proposed project is consistent with the GOT's commitment to effectively address the high levels of malnutrition reflected in the NMNAP 2016-2021, as noted above.** The expected long-term impact of the full implementation of the NMNAP is that "children, adolescents, women and men in Tanzania are better nourished leading to healthier and more productive lives that contribute to economic growth and sustainable development." The government's emphasis on IEY is indicated by five out of the nine key targets in the plan that focus on nutrition among children age under five and women of reproductive age. Furthermore, NMNAP is aligned with the government's development agenda (i.e., FYDP II), and makes a clear link between investing in the nutrition agenda, and the goal of moving the country into a middle-income status.

16. **The proposed project is also consistent with the GOT's Health Sector Strategic Plan (July 2015 – June 2020) (HSSP IV).** Of relevance is a strategic direction that is articulated in the plan: the health sector, in collaboration with partners, will accelerate nutrition interventions, with emphasis on pregnancy and the first two years of life (1,000 days). The HSSP IV draws on the Essential Nutrition Action approach which aims to reach at least 80 percent of caregivers through health services, with the goal of reducing underweight among children from 16 percent to 11 percent in 2020, and stunting among children from 42 percent to 27 percent in 2020.

### C. Proposed Development Objective(s)

The Project Development Objective (PDO) is to improve coverage and quality of the early childhood development services for the first 1,000 days in selected regions.

#### Key Results (From PCN)

17. **Progress toward the PDO achievement will be measured through the following set of proposed outcome indicators in the selected regions.** As the proposed project will focus on selected regions, data will be monitored at the regional level as well as national level for the selected regions.

- Percentage of targeted children receiving growth monitoring and promotion services
- Percentage of targeted children 6-23 months that have been fed with minimum acceptable diet
- Percent of primary caregivers engaged in early stimulation activities for children 0-23 months during the last three days
- Percentage of targeted pregnant women who received adequate quantity of iron and folic acid tablets during their current antenatal care visit (enough supplies for next visit)
- Percentage of targeted women using modern contraceptives

18. **The final selection of indicators and targets for the proposed project will be refined throughout project preparation.** Targets for each indicator will be set with an appropriate level of ambition, considering the synergistic effects of ongoing and pipeline projects, as well as past trends. The project will draw on several sources of data. Routine health/nutrition information systems as well as project administrative data will be used to the extent possible, but routine short surveys (e.g., SMART survey methodology) may be also necessary. The project will also draw on



general population surveys, such as the Tanzania Demographic and Health Survey and the Tanzania National Nutrition Survey to triangulate the data.

#### D. Concept Description

19. **Investing in young children through ECD programs is one of the smartest investments a country can make to address inequality, break the cycle of poverty, and improve outcomes later in life.** Early childhood provides an unequalled period for the development of human capital Tanzania needs for industrialization goals as well as its development goal to become a middle-income country by 2025. To improve coverage and quality of the ECD services in Tanzania, several key ingredients are required: (i) regular behavior change communication sessions that reach parents, caregivers and children in the communities to enhance their knowledge and create an environment conducive to behavior change; (ii) delivery of high quality essential services at communities and facilities (including health facilities) that respond effectively to women and children's needs in health, nutrition, and early stimulation; and (iii) policy, implementation framework and systems that bring together interventions that cut across several sectors.

20. **Given sub-optimal delivery of ECD services and weak demand, project components focus on generating demand for, and strengthening supply of quality ECD services.** Integration and coordination at community, facility, LGA and national level is key to improving availability and quality of essential ECD services. To improve availability and quality of nutrition as well as early stimulation interventions, the project components will focus on improving implementation and management capacity as well as coordination of various interventions by different actors across the sectors at the community, facility, LGA and national levels. On the demand-side, emphasis will be placed on community empowerment with the aim of increasing demand for essential services known to improve ECD outcomes, and improving pro-ECD knowledge, attitudes and practices through community-based education and promotion.

21. **The exact mechanisms for targeting and areas of geographic focus will be defined during project preparation.** Key considerations in the final selection of priority regions include: poverty and ECD outcomes, coverage of key ECD services, presence and coverage of programs supported by DPs (both on-going programs as well as those in the pipeline), and opportunities of alignment and convergence with other projects/programs.

22. **Component 1: Community-Based Services** aims to increase demand for essential services known to improve ECD outcomes and improve pro-ECD knowledge, attitudes and practice through community-based education and promotion. This component will focus on the demand-side by engaging and empowering communities to promote child development with a focus on nutrition and early stimulation. This will be achieved through activities that: (i) build a community based service delivery platform; and (ii) roll out a package of community based high impact interventions through the platform. The World Bank will work with the government on an extensive stocktaking to review the coverage of key ECD interventions and opportunities to address gaps.

23. **Based on a request from the government, the proposed project will consider rolling out CBHP** by contracting trained CHWs to provide services until the government absorbs them into the system as the newest service providers serving as a critical bridge between individuals and higher-level health services in facilities. Specifically, the package of interventions to be delivered by CHWs include, among others: (i) education and promotion of optimal maternal, infant, and young child and adolescent health and nutrition (MIYCAHN) practices including use of bed nets, full immunization, promotion of WASH, vitamin A supplementation, deworming, and utilization of micronutrient powders; (ii) growth





monitoring and promotion (GMP); (iii) community-based integrated management of childhood illnesses (C-IMCI) including early detection of danger signs of acute respiratory infection and diarrhea and management (e.g., amoxicillin, oral rehydration solution and zinc); (iv) integrated management of acute malnutrition (IMAM) such as early identification, management, referral, and follow up; (v) promotion of adequate reproductive health including distribution of contraceptives; and (vi) promotion of child protection including positive parenting. Given the critical role parents and caregivers play in promoting healthy development of children, this component will also support systematic incorporation of parenting and caregiver education for early stimulation into existing MIYCAHN programs as well as social welfare/child protection at the community level. Further analysis will be undertaken during preparation to guide the best option of the community-based service delivery platform and roll out community level services to those who need them the most. This component will support: (i) contracting in and induction/refresher training of CHWs; (ii) community mobilization and sensitization of CBHP among various stakeholders; and (iii) supplying initial equipment and supplies for CHWs that can enable them to deliver CBHP service package.

24. **Component 2: Facility-Based Services** aims to improve delivery of essential services for women and children that are known to improve ECD outcomes including nutrition and cognitive development. Facilities will include health facilities as well as other types of institutions such as child care centers, where ECD services for children in the first 1,000 days are being implemented or planned. The primary aim of the activities under this component is to strengthen and improve the quality of essential services that are known to improve ECD outcomes with a focus on nutrition by addressing the weaknesses and filling the gaps in the current performance of services for children as well as their mothers. Activities under this component will include: (i) in-depth analysis of weaknesses and gaps in the current performance; (ii) revision of various curriculum and training materials to integrate ECD services (e.g., early stimulation into MIYCAHN, nutrition into Productive Social Safety Net Program sensitization training materials, WASH promotion (hygiene/handwashing as well as safe disposal of stools) into crèche/child care centers, etc.); (iii) training of service providers (health workers and child care staff); (iv) supply of equipment and commodities needed in delivering the integrated ECD services critical to improving ECD outcomes such as MIYCAHN, GMP, IMCI, IMAM, and early stimulation/learning; and (iv) delivery of the integrated ECD packages (e.g., WASH day at crèche; early stimulation promotion at child welfare clinics, etc.). Priority will be given to essential inputs needed for the continuum of care with a focus on preventive and promotive services during the critical months within the 1,000-day period. Pilot-testing of different facility-based delivery platforms is also envisaged under this component.

25. **Component 3: National and LGA Level System Strengthening** aims to positively influence individual behavior and social norms affecting ECD outcomes through social and behavior change communication (SBCC); and develop and strengthen systems that can improve sustainability.

26. **Subcomponent 3.1: Enhance SBCC:** aims to increase knowledge and create an environment that is conducive to the desired behavior change, i.e., pro-ECD behaviors, including adoption of behavior that affects the nutrition and developmental status of young children, and women. This sub-component will support development and implementation of: (i) nation-wide SBCC campaigns, such as the National Sanitation Campaign, on a sustained basis; and (ii) community-level sensitization efforts (e.g., local radios, drama) that can enhance knowledge and influence behavior as well as social and cultural norms that impede demand for essential services and behavior change that lead to favorable ECD outcomes.



27. **Subcomponent 3.2: Strengthen the system to deliver quality ECD services:** aims to strengthen the institutional and implementation arrangements including inter-sectoral coordination for ECD policy planning and development at all levels. This sub-component will support: (i) policy and costed implementation strategy development and approval; (ii) operational research; (iii) capacity development for better management and coordination among key stakeholders at LGA and national levels and knowledge sharing, including learning exchanges; (iv) improvement of the multi-sectoral information systems to enable tracking of key performance indicators related to ECD including nutrition; and (v) improvement of the supply chain management system to improve flow of commodities.

28. **Subcomponent 3.3: Improve project management, coordination, monitoring and evaluation (M&E):** aims to improve capacity of national implementing entities to effectively manage the project implementation, coordinate various entities, and monitor the implementation progress and evaluate effects of the project. This sub-component will support: (i) day-to-day management of project activities including fiduciary and citizen engagement activities; (ii) technical assistance and capacity building activities to support the implementing entities with varying capacities; and (iii) M&E activities such as periodic surveys, and process evaluation to monitor implementation progress and address any implementation challenges.

## **SAFEGUARDS**

### **A. Project location and salient physical characteristics relevant to the safeguard analysis (if known)**

The exact mechanisms for targeting and areas of geographic focus will be defined during project preparation. Based on the initial mapping of key DP supported nutrition programs, the GOT team will: (i) determine the selection criteria; (ii) compile and review data; and (iii) present the information with the list of priority regions to the GOT/World Bank teams. Key considerations in the final selection of priority regions include: poverty and ECD outcomes, coverage of key ECD services, presence and coverage of programs supported by DPs (both on-going programs as well as those in the pipeline), and opportunities of alignment and convergence with other World Bank financed projects across the sectors such as the rural WASH program.

### **B. Borrower's Institutional Capacity for Safeguard Policies**

The Borrower has a national legislation and procedure for environmental management. The National Environment Management Council (NEMC) is a semi-autonomous entity with a mandate to monitor compliance of the environmental law through Sector Environmental Units and Local Government Authorities. The Ministry of Health & Social Welfare has an environmental health unit (under the Directorate of Preventive Services), which is responsible for the implementation of a national Health Care Waste Management Plan (HCWMP). Supervision of the implementation of the HCWMP at all levels, including all health facilities (particularly hospitals) is under the responsibility of the Directorate of Preventive Services. However, due to the low risk nature of proposed project activities, safeguards implementation capacity issues are not anticipated to affect the Project Development Objective.

### **C. Environmental and Social Safeguards Specialists on the Team**

Mary C.K. Bitekerezoo, Social Safeguards Specialist

Jane A. N. Kibbassa, Environmental Safeguards Specialist



**D. Policies that might apply**

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	Triggered due to the potential generation of health care waste. No large scale, significant and/or irreversible impacts are anticipated.
Natural Habitats OP/BP 4.04	No	The project will not undertake any investments that may impact on natural habitats.
Forests OP/BP 4.36	No	The project is not expected to impact forests.
Pest Management OP 4.09	No	The project is not expected to impact pests.
Physical Cultural Resources OP/BP 4.11	No	The project is not expected to have an impact on physical cultural resources.
Indigenous Peoples OP/BP 4.10	TBD	The areas of geographic focus will be defined during project preparation. Based on the target areas and activities selected, application of this OP will be assessed.
Involuntary Resettlement OP/BP 4.12	No	The project will not involve any activities that would result in land acquisition, physical displacement, economic displacement or any other form of involuntary resettlement as defined by the policy.
Safety of Dams OP/BP 4.37	No	The project will not invest in dams nor will project activities rely on dams.
Projects on International Waterways OP/BP 7.50	No	The project activities are not expected to affect international waterways.
Projects in Disputed Areas OP/BP 7.60	No	The project will not be located in a disputed area.

**E. Safeguard Preparation Plan**

Tentative target date for preparing the Appraisal Stage PID/ISDS

Jun 22, 2018

Time frame for launching and completing the safeguard-related studies that may be needed. The specific studies and their timing should be specified in the Appraisal Stage PID/ISDS

This project is expected to attract no land acquisition as no civil works are envisioned at this point. The project components will focus on improving implementation capacity as well as coordination of various interventions by different actors across the sectors at community, facility, LGA and national levels. The project does not anticipate financing any physical activities, but is expected to increase utilization of health services. Community based services will be mostly preventive and promotive (e.g., behavior change education/promotion, growth monitoring, etc.) and thus the project is unlikely to generate “additional” health care waste. The project will finance procurement of commodities (e.g., iron-folate tablets, etc.), supplies (e.g., SBCC materials, etc.) and equipment (e.g., weighing scale, etc.) to improve quality of essential services at the facility level. There are no large scale, significant and/or long term environmental or social impacts



anticipated due to project activities. Since there is the potential for increased health care waste generation, the project will update the Health Care Waste Management Plan. The updated HCWMP will be consulted and disclosed prior to appraisal. The project is assigned the Environmental Category B.

**CONTACT POINT**

**World Bank**

Yi-Kyoung Lee  
Senior Health Specialist

**Borrower/Client/Recipient**

Ministry of Finance and Planning  
Mr. Doto James  
Permanent Secretary  
ps@mof.go.tz

**Implementing Agencies**

President’s Office Regional Administration and Local Government  
Eng. Mussa Iyombe  
Permanent Secretary  
psporalg@tamisemi.go.tz

Ministry of Health, Community Development, Gender, Elderly and Children  
Dr. Mpoki Ulisubisya  
Permanent Secretary  
ps@moh.go.tz

**FOR MORE INFORMATION CONTACT**

The World Bank  
1818 H Street, NW  
Washington, D.C. 20433  
Telephone: (202) 473-1000  
Web: <http://www.worldbank.org/projects>

**APPROVAL**

Task Team Leader(s):	Yi-Kyoung Lee
----------------------	---------------



**Approved By**

Safeguards Advisor:	Nathalie S. Munzberg	16-Nov-2017
Practice Manager/Manager:	Evelyn Anna Kennedy	17-Nov-2017
Country Director:	Preeti Arora	28-Nov-2017

---