THE UNITED REPUBLIC OF TANZANIA

TANZANIA REPRODUCTIVE MATERNAL NEONATAL CHILD AND ADOLESCENT HEALTH AND NUTRITION (RMCAH-N) INVESTMENT PROJECT (P170435)

ENVIRONMENTAL AND SOCIAL SYSTEMS ASSESSMENT (ESSA)

Prepared by the World Bank

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ACRONYMS AND ABBREVIATIONS

Short Form	Description
ANC	Ante- Natal Care
APER	Annual Performance Evaluation Report
BEmONC	Basic Emergency Obstetric and Neonatal Care
BRNH	Big Results Now in Health
CBHS	Community-based Health Services
CBHP	Community Based Health Programs
CCHPs	Comprehensive Council Health Plans
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CHMT	Council Health Management Teams
CHWs	Community Health Workers
CPD	Continuing Professional Development
CPF	Country Partnership Framework
CSO	Civil Society Organization
COVID-19	Corona Virus Disease
DED	District Executive Director
DHFF	Direct Health Facility Funding
DHIS	District Health Information System
DLIs	Disbursement-linked Indicators Environment
EMA	Environmental Management Act
ESSA	Environmental and Social Systems Assessment
ESMF	Environmental and Social Management Framework
ESMP	Environmental and Social Management Plan
EWURA	Energy and Water Utilities Regulatory Authority
GAC	Governance and Anti-corruption
GBV	Gender Based Violence
GDP	Gross Domestic Progress
GFF	Global Financing Facility
GoT	Government of Tanzania
GPSA	Government Procurement Services Agency
GRC	Grievance Redress Committee
GRS	Grievance Redress Service
HAI	Hospital Acquired Infections
HBF	Health Basket Fund
HBS	Household Budget Survey
HCW	Health Care Waste
HCWM	Health Care Waste Management
HDI	Human Capital Index
HEPRU	Health Emergency Preparedness Unit
HFGC	Health Facility Governing Committee

HMIS	Health Management Information Systems
HRH	Human Resource for Health
HSSP	Health Sector Strategic Plan
LGAs	Local Government Authorities
IDA	International Development Association
IPT	Intermittent Preventive Therapy
KRA	Key Results Area
LGA	Local Government Authority
MoH	Ministry of Health
MOH	Ministry of Health, Social Welfare, Elderly, Gender and Children (Zanzibar)
MKUKUTA	Government National Strategy for Growth and Poverty Reduction
MMAM	Mpango wa Maendeleo wa Afya ya Msingi (PHSDP)
MMR	Maternal Mortality Ratio
Short Form	Description
MNCH	Maternal, Neonatal Child Health
MOFP	Ministry of Finance and Planning
MOU	Memorandum of Understanding
NEMC	National Environment Management Council
NHIF	National Health Insurance Fund
OHS	Occupational Health and Safety
OPD	Outpatients Department
OSHA	Occupational Safety and Health Agency
PBCs	Performance Based Conditions
PDO	Program Development Objective
PforR	Program for Results
PHC	Primary Health Care
PHSDP	Primary Health Services Development Programme
PMTC	Prevention of Material to Child Transmission of HIV Virus
POM	Program Operations Manual
PO-RALG	President's Office – Regional Administration and Local Governance
RBF	Results-based Financing
RHMT	Regional Health Management Teams
RMNCAH –N	Reproductive, Maternal, Newborn, Child and Adolescent Health
RRH	Regional Referral Hospital
Sac	Social Accountability
SEA-SH	Sexual Exploitation and Abuse-Sexual Harassment
SWAp	Sector Wide Approach
TDHS	Tanzania Demographic Health Survey
TFNC	Tanzania Food and Nutrition Centre
TMDA	Tanzania Medicines & Medical Devices Authority
ToR	Terms of Reference
USAID	United States Agency for International Development

VPO-Envt	Vice-President's Office – Environment
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization
WISN	Workload Indicators of Staffing Needs

EXECUTIVE SUMMARY

ES1. Introduction

The Tanzania Reproductive Maternal Neonatal Child and Adolescent Health Project (Invest in People) project is intended to scale up priority RMNCAH-N interventions and address selected health system bottlenecks relevant for RMNCAH-N. The project draws lessons from the previous project (Strengthening Primary Health Care for Results Program, P152736), from other programs in the country and from global experiences. The project is meant to cover both Tanzania Mainland and Zanzibar, each with separate funding mechanism and implementation arrangements. Tanzania Mainland will use the Program-for-Results Financing and Zanzibar will use Investment Project Financing.

The PforR Program will finance essential RMNCAH-N services at the PHC level countrywide, selected regional referral hospitals, and activities to strengthen referral services at district and regional levels. It will focus on realizing the main RMNCAH-N priorities and the relevant health system functions for effective provision of RMNCAH-N services. The project will prioritize obstetric and newborn care, family planning and adolescent health, emergency and referral services, quality care, and ensuring functionality of the existing health infrastructure. Besides using Performance Based Conditions (PBCs), the project's implementation will be mainstreamed, and part of its funding channeled through HBF. The PforR Program will support five Key Results Areas (KRAs) aligned with the HSSP V strategic directions, namely: (i) RMNCAH-N services; (ii) human resources for health; (iii) emergency and referral services; (iv) health facility performance and functionality; and (v) management and accountability functions. This Environmental and Social System Assessment (ESSA) was prepared to guide the implementation of the project in meeting environmental and social safeguard requirements in Tanzania mainland which makes use of the Program for Results (PforR) financing instrument.

ES2. Project targeted beneficiaries

The primary beneficiaries of the project are women of the reproductive age, adolescents, and children under five, including newborns and infants who will benefit from a package of high impact quality and cost-effective RMNCAH -N interventions. In addition, health workers as well as management staff of the health facilities under the program will benefit as secondary beneficiaries of the Program. Apart from these beneficiaries, other members of the communities will benefit from improved health services.

ES3. ESSA Background and objectives

This Environmental and Social Management System Assessment (ESSA) identifies the key environmental and social risks (E&S), that are likely to affect the achievement of the development outcomes. Also, it assesses the capacity of the Government's existing environment and social management systems that are the legal, regulatory and institutional frameworks guiding the Programme. It then defines and recommends measures which have to be proposed in order to strengthen the systems, and which should be integrated into the overall Program in order to manage environmental and social risks. The ESSA was conducted to ensure consistency with the six Core Principles outlined in the World Bank's Operational Policy Directives as revised in 2022 - Program-for-Results Financing Policy Frameworks [i) Bank Policy - Program-for-Results Financing - OPS5.04-POL.107 (Last Revised On 03/25/2022); ii) Bank Directive - Program-for-Results Financing - OPS5.04-DIR.107 (Last Revised On 03/08/2022); iii) Bank Guidance -Program-for-Results Financing - Environmental and Social Systems Assessment - OPS5.04-GUID.118 (effective 09/18/2020)].. Thus, it presents the findings of the ESSA exercise and makes recommendations.

To achieve the aforementioned objectives, the ESSA exercise employed: extensive stakeholder consultations and public participation; review of the relevant laws, regulatory frameworks, and guidelines; assessment of the potential environmental and social risks of the activities proposed under the Program; assessment and review of the institutional roles and responsibilities in environmental and social management; and analysis of current capacity of the government's systems to carry out those roles and responsibilities in the Program. The ESSA consultation process and contents are embedded in the Program. The first consultation meetings were conducted on 7th December 2021. The meeting involved participants implementing institutions (such as the Ministry of Health), government institutions, as well as NGOs, CSOs and CBOs. It was followed by field visits in selected Health facilities in Dodoma region. The second round of stakeholders' consultations took place from 21st to 23rd March 2022 in Dar es Salaam and Dodoma regions and it involved Government Ministries, academic institutions, Civil Society Organizations (NGOs and CBOs), IPs and PWDs. Given the spread of Covid-19 pandemic, a hybrid method, combining both virtual and physical meetings was adopted to accommodate the different categories of stakeholders.

The Program's intent is to scale-up the provision of essential primary health care services and improve their quality, with the focus being on Reproductive Maternal Neonatal Child and Adolescent Health-Nutrition (RMNCAH-N) Services. This will be achieved by improving service delivery, strengthening the relevant systems and financing the civil works related with upgrading and improvement of health infrastructural conditions and utility services in the existing primary health care facilities. The programme is not expected to have a significantly adverse environmental or social footprint if construction activities and healthcare facility operations are well managed. It is expected that the impact of the programme will be moderate since the infrastructural rehabilitation and construction works will be confined in the premises of the existing Primary Health Care (PHC) facilities.

The ESSA analysis presented in this document identifies strengths, gaps and opportunities in Tanzania's environmental and social management system with respect to the issue of addressing the environmental and social risks associated with the programme. The analysis identifies the following main areas for action in order to ensure that the Program interventions are aligned with the Core Principle 1, 3 and 5 of OP/BP 9.00 applicable to the programme, namely Health Care Waste Management and Social Accountability. The gaps identified through the ESSA and the subsequent actions to fill those gaps are expected to directly contribute to the attainment of the Program's intended results related in enhancing the quality of primary health care (PHC) services nationwide, particularly maternal, neonatal and child health (MNCH) services.

The objective of the ESSA was to review the capacity of the government's existing systems (National, Regional and District level systems) to plan and implement effective measures for managing environmental and social risks and impact in the RMNCAH -N programme; and to find out if there are any measures that require to be strengthened. So, it assessed the environmental and social systems that are in place, the human resources, their competencies, the gaps /weaknesses, and nature of necessary improvements that would form the basis of the program's action plan.

Findings: Based on its findings, the ESSA concluded that Tanzania's environmental and social management systems are adequate for addressing the environmental, health, safety, and social risks associated with the RMNCAH-N program and are consistent with the six core principles of the World Bank's policy on effective management of programme risks and promotion of sustainable development under the programme for results financing.

The national government has well developed and robust legislations, regulations, and systems to manage environmental, health, and safety risks. The national EIA system has well-defined guidelines on project registration and screening, EIA process (scoping, alternative analysis, impact assessment, mitigation measures, management plan and consultation), monitoring and auditing, and decommissioning. Also, it had systems overseeing occupational health and safety at workplaces, protecting workers against exploitation; and advancing social protection.

ESSA has found that the Ministry of Health and the President's Office Regional Administration and Local Government are committed to protect public health against risks associated with healthcare wastes as stipulated in various policies and strategies such as The National Policy Guidelines for Health Care Waste Management in Tanzania (2017), and the National Strategic Plan for Healthcare Waste Management (2018 -2022).

The interventions under the programme that involve expansion of the provision of health services, construction and renovation of health facilities, and improvement in procurement and the subsequent use of medical equipment and products (medicines and supplies) are associated with environmental and social risks and impacts. The risks and impacts include generation of solid waste including Healthcare wastes, health and safety hazards (HSH), accidents and emergencies, dust and air pollution. The anticipated social risk and impacts include GBV, sexually transmitted diseases (STDs), spread of Covid-19 virus, violation of workers' rights, and land take leading to displacement of people and economic activities. Land take is only in case the construction of health infrastructure will not be confined within the existing health facilities.

ESSA also noted that there is limited awareness of environmental health risks associated with poor quality of water, limited capacity to manage them, inadequate sanitation and poor hygiene. This emanates from the fact that training on roles and responsibilities of councils is done only to the committees and not to the community they serve. The situation is even more complicated as the coverage of the training programme is constrained by inadequacy of financial resources. In addition, the healthcare waste management programme is highly under-resourced (manpower and funds), something which prevents it from providing satisfactory oversight. Again, ESSA found a serious fault in the provision of contraceptives to young girls in order to prevent early pregnancies. This means more emphasis has to be placed on educating both young girls and boys on matters concerning their reproductive health.

The aforementioned risks and impacts can be managed well and addressed promptly by observing the existing legislations such as Environmental Management Act of 2004, the Occupational Health and Safety Act No. 5 of 2003, the Public Health Act of 2009, the Employment and Labour Relations Act No. 6 of 2004, and the National Plan of Action to End Violence against Women and Children in Tanzania of 2017/8-2021/2 (NPA-VAWC 2017/18 – 2021/22). Operationalization of the National Policy Guidelines for Health Care Waste Management in Tanzania (2017); the National Strategic Plan for Healthcare Waste Management (2018 -2022) are also instrumental in managing of healthcare waste; and enhancing the capacities of incinerators existing at various health facilities.

As per ESSA, challenges may arise if there will be lack of compliance to the environmental and social requirements as per the country's laws and regulations at national, regional and district levels. Some may arise due to weaknesses in the implementation of health waste management practices as a result financial, human resource and other capacity-related constraints. Regulations on hazardous wastes (including health care waste), air and Water quality are in place. There are also insufficient participatory Planning, implementation and monitoring due to capacity-related constraints including lack of incentives. As well, not all health facilities in the country have well-formed governing committees and where such committees

exist, they are not fully functional to be able to apply ***social accountability mechanisms*** that include grievance redress. Application of the social accountability (SAc) mechanisms and other participatory tools is dismal. The issue of compliance can, however, be improved during the implementation of the programme depending on the level of implementation and supervision by both the Bank and the country's implementation agencies.

ESSA concludes that Tanzania's environmental and social management system has adequate capacity to manage the risks associated with the RMNCAH-N program. The analysis also identifies a number of actions that can help to ensure proper management of environmental and social risks associated with the programme. These measures are linked closely with the Disbursement-linked Indicators (DLIs) for the P-for-R operation, specifically: DLI 3 (which represents performance of Maternal, Neonatal and Child Health service delivery at Primary Health Care facilities), DLI 4 (which represents annual performance in Maternal, Neonatal and Child Health service delivery at the local government authorities' level), and DLI 7 (Completion of annual capacity building activities at all levels). The measures are defined in Table 'i' below. The suggested key measures will be embedded in RMNCAH-N's Program Action Plan.

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

Target Objective	Measures to be Taken
Ensure effective implementation of the Tanzanian environmental and social management system for the PforR program related to management of Health Care Waste (HCW).	○ Increase capacity of waste disposal infrastructure at health facilities at all levels (national, regional, district and primary). ○ Strengthen the capacity for monitoring, supervision and enforcement of national guidelines on HCW management. ○ Operationalize the existing HCW management guidelines. ○ Include HCWM and Community Engagement plans in the Comprehensive Council Health Plans (CCHP) to improve HCWM. ○ Update technical guidance for better waste management (health care and construction), asbestos and incinerator management, occupational safety and hygiene practices. ○ Undertake needs assessment/feasibility study to ascertain the capacities and conditions of existing incinerator at relevant health facilities to guide intervention.
Increase coordination among various ministries, agencies and donor partners on environmental and social aspects.	○ Avail more information to the public ○ Improve coordination among various ministries (led by MoH), agencies and donor partners in respect to environmental and social aspects to further support implementation and information sharing through publicly available mechanisms. ○ The Program Operations Manual to include measures to improve information disclosure and stakeholder consultations.
Protect project workers, local communities, and vulnerable groups against labour exploitation, GBV/SEA, STDs, and COVID-19.	○ Maintain effective collaboration with OSHA and Ministry of Labour and Employment on health, safety, and labor management issues.

Target Objective	Measures to be Taken
	○ Develop and Operationalize the Workers' code of conduct including GBV/SEA prevention and response. ○ Mainstream Ministry of Health COVID-19 Management Protocol in all civil works and public consultation and engagement. ○ Enhance existing mechanisms for grievance redress and complaint handling.
Enhance transparency and information sharing, grievance redress, and community participation.	○ Ensure inclusive and participatory consultations and feedback for social accountability along with improved focus on gender and other vulnerable groups also need improvement.
Addressing Capacity Constraints	○ Undertake capacity building and training actions for improved implementation, including infection control, waste management, how to administer social accountability mechanisms, and grievance redress. These will be integrated in the Program's capacity building plan. ○ Provide capacity buildings on HCWM to E&S Specialists at Implementing Entities/Agencies and workers at health facility levels
Ensure that the designs of the existing health facilities are supportive to hygiene practices and accommodation of waste water treatment services.	○ The Health facilities to be constructed/upgraded to be supplied with supportive facilities that enhance hygiene practice e.g. washing facilities, toilets, water storage tanks (reservoirs), bathrooms, tiles, and appropriate facilities for wastewater treatment e.g. septic tanks or connection to sewerage systems.
Improved systems for Information Disclosure and Stakeholder Consultation to ensure that the benefits of the Program reach all beneficiary groups (service users and providers).	○ The Program to avail more information to the public ○ Increased coordination led by MoH among various ministries, agencies and donor partners on environmental and social aspects to further support implementation ○ Information sharing through publicly available mechanisms. ○ The Program Operations Manual to include measures to improve information disclosure and stakeholder consultations.
Ensure land is acquired in accordance with Tanzanian land laws.	○ Confirm that acquisition of land is consistent with the Tanzanian land laws.

SECTION I: PROGRAM DESCRIPTION

1.1 Introduction

1. **The United Republic of Tanzania is a union between Tanzania Mainland and Zanzibar.** Its population in 2020 was estimated at 57.6 million inclusive of 1.67 million in Zanzibar (NBS 2018). Much of the population is young, with a median age of 18 years and growing at about 3 percent annually, putting Tanzania among the countries with the fastest population growth rates globally, driven partly by the high total fertility rate and reduction in childhood mortality. The country is undergoing rapid urbanization. In 2020, about 34.5 percent of its population (46 percent for Zanzibar) was designated as urban compared with 19 percent in 1988.

2. **The national poverty rate in Tanzania has declined from 34.4 to 26.4 percent between 2007 and 2018.**[1] Over the same period, poverty in rural areas dropped from 39.1 to 33.1 percent, compared to 20.0 to 15.8 percent in urban areas. While there has been an overall drop in poverty, a large proportion of the population remains vulnerable to falling back into poverty. In 2018 almost half the population was living below the international poverty line of US$1.9 per day. Due to the increasing population, the absolute number of poor people increased from 12.3 million in 2011 to about 14 million in 2018.

3. **Prior to the outbreak of novel coronavirus disease (COVID-19), Tanzania was experiencing robust and sustained economic growth**. With an economy growing at an annual average of over 6 percent for two decades, Tanzania in 2020 graduated to a lower-middle-income country (LMIC) status. Although the government did not impose mobility restrictions, the COVID-19 pandemic inflicted a shock on the Tanzanian economy, adversely impacted livelihoods, increased uncertainty and slowed the gross domestic product (GDP) growth rate to 2.5 percent in 2020, in contrast with 6.9 percent in 2019. Moreover, Tanzania's performance in terms of human development is low. The Human Capital Index (HDI) in Tanzania in 2020 was estimated at 0.39, which is below its expected level for development, and places it among the bottom 35 countries globally.

4. **Tanzania's vision is to improve livelihoods of its people and develop a strong and competitive economy (Vision 2020).** The three pillars of transformation, namely, industrialization, human development, and implementation effectiveness outlined in the National Development Plan (2016/17 – 2020/21) remain relevant to the current context of Tanzania. Similarly, Zanzibar's Development Vision 2050 (ZDV50) is centered on human development and economic growth and is founded on four pillars, namely economic transformation, human capital and social services, infrastructural linkages and governance and resilience. However, with a low human development base and uncertainty about global recovery from COVID-19 pandemic, Tanzania will require to prioritize and sustain investments so as to maintain its growth momentum and improve the quality of life of its people, especially the poor and vulnerable.

1.2 Program Concept

5. **The program is intended to contribute towards scaling up priority RMNCAH -N interventions and addressing selected health systems bottlenecks relevant to RMNCAH -N**. The project draws on lessons from the previous project, Strengthening Primary Health Care for Results Program (P152736), and from other programs in the country and from global experiences. The project will cover both Tanzania Mainland and Zanzibar, each with separate funding mechanism and implementation arrangements. For Tanzania mainland the Programe will follow the Program-for-Results (PforR)

[1] World Bank, Tanzania Mainland Poverty Assessment, 2018. The national basic needs poverty line for 2018 was TZS 49,320 per adult per month and the food poverty line (extreme poverty) was TZS 33,748

Financing and Zanzibar will follow the Investment Project Financing (IPF). The IPF is suitable for Zanzibar as this will be the first time it implements a World Bank-financed health operation. For mainland Tanzania, the PforR is the most suitable lending instrument to support the proposed operation for the following reasons:

a) It promotes a focus towards policies and sector results, moving away from specific inputs found in traditional sector investment or operations, and supports the governments' own agenda using country systems with due attention to systems strengthening, which will enhance development impact and sustainability.
b) It makes the Bank's contribution more flexible and responsive to country's needs with the provision of non-earmarked funds and allows the Bank to effectively harmonize its support with funding from the government and other DPs, increasing the leverage of Bank's resources.
c) Mainland Tanzania already has considerable experience with the PforR instrument with several programs under implementation including the recently closed Strengthening PHC for Results Program (P152736), which was executed by the MoH and PORALG.

Mainland Tanzania already has considerable experience with the PforR instrument with several programs under implementation including the recently closed Strengthening PHC for Results Program (P152736), which was executed by the MoH and PORALG.

6. The government program in mainland Tanzania is a slice of the HSSP V comprising primary health care (PHC) services, regional referral hospitals and referral services. In mainland Tanzania, PHC services are delivered within a devolved arrangement at the district level, involving district hospitals, health centers, dispensaries, and community-based health services under the management of Council Health Management Teams (CHMTs). The plans for the PHC facilities are consolidated within the Comprehensive Council Health Plans (CCHPs) under 13 priority areas. The program is focused on improving provision and quality of health services and health systems performance in areas relevant to delivery of RMNCAH-N services. Regional referral hospitals are under the central MoH and provide the bulk of secondary health services including referral services for the management of emergencies and critically ill patients covering the following major specialties: general surgery, obstetrics and gynecology, internal medicine, and pediatrics.

7. The HSSP V has four strategic priorities, namely: (a) provision of health services; (b) organization of health services; (c) health system performance; and (d) health system investments and functioning. Drawing from the HSSP IV mid-term review findings, the HSSP V prioritizes scaling up MCH services, improving quality of care, addressing the persistent staffing challenges, ensuring functionality of the health facilities, strengthening governance and management functions, and expanding use of electronic management information systems in the sector. The government program is also guided by the National Road Map Strategic Plan to Improve Reproductive, Maternal, Newborn, Child, and Adolescent Health (One Plan III, 2020 - 2025), whose goal is to improve delivery of quality RMNCAH-N services by strengthening institutional capacity and increasing access and utilization of the RMNCAH-N services in an equitable manner. The HSSP V based on the prioritized scenario is anticipated to save more than 200,000 additional lives and avert more than 400,000 disability-adjusted life years while One Plan III is anticipated to avert more than 100,000 child deaths, nearly 20,000 maternal deaths, and more than 40,000 stillbirths.

1.3. PforR Program Scope

8. The scope of the government program and the proposed PforR Program is outlined in Table 1 below. The PforR Program will finance essential RMNCAH-N services at the PHC level countrywide, selected regional referral hospitals, and activities to strengthen referral services at district and regional levels. The primary beneficiaries of the program are women of reproductive age, adolescents, and children under the ages of five years including newborns and infants who will benefit from a package of high impact quality and cost-effective RMNCAH-N interventions. In addition, health workers as well as management staff of the health facilities under the program will benefit as secondary beneficiaries of the Program. Improved service delivery is expected to benefit other community members. The PforR Program will support five Key Results Areas (KRAs) aligned with the HSSP V strategic directions, namely: (i) RMNCAH-N services; (ii) human resources for health; (iii) emergency and referral services; (iv) health facility performance and functionality; and (v) management and accountability functions.

Table 1. Government Program and the Proposed PforR Program

	Government program	Program supported by the PforR	Reasons for non-alignment
Objective	Increase life expectancy and quality of life of citizens, especially among those most at risk, by establishing a health care system that meets the needs of all citizens.	To scale-up provision and improve quality of essential PHC services with a focus on RMNCAH-N Services.	The PforR supports a slice of the government program and achievement of its objective will contribute to the government's program objective.
Duration	2021-26	2022-27	The PforR operation ends a year after the government program
Geographic coverage	National	National	
Results areas	Strategic Outcomes: 1. Provision of health services 2. Organization of health services 3. Health system performance, and 4. Health system investments and functioning	Key results areas: 1. Maternal and child health services 2. Human resources for health 3. Emergency and referral services 4. Health facility performance and functionality 5. Management and Accountability	The PforR will support selected parts of the government's overall national health sector program that are focused on improving delivery of PHC and referral services.
	The activities to achieve the PforR results will be embedded in relevant strategic outcomes and government budgets. The government's strategic outcome 1 "provision of health services" will encompass activities contributing to the PforR Results Area 1 "maternal and child health services." The government's strategic outcome 2 "organization of health services" will encompass activities contributing to the PforR Results Areas 3 "emergency and referral services" and Results Area 5 "management and accountability". The		

	government's strategic outcome 3 "health system performance" will contribute to Results Area 4 "health facility performance and functionality," while the government's strategic outcome "health systems investments and functioning" will include activities to strengthen human resources for health under the Results Area 2 and activities on medicines and infrastructure under Results Area 4.		
Overall Financing	**US$2.347 billion**	**US$205 million**	

9. The scope of the proposed Program includes recurrent and operating costs, goods, small works, and services. In accordance with the World Bank's Policy and Directive on PforR Financing, it excludes high-risk and high value activities, defined as those that: (i) are judged to be likely to have significant adverse impacts that are sensitive, diverse, or unprecedented on the environment and/or affected the population; and/or (ii) involve procurement of goods, works, and services under high-value contracts. The total cost of the government program is estimated at US$2.347 billion over the next five years, of which US$205 million (9 percent of the total Program cost) will be financed under the proposed PforR operation. Funding for the PforR operation includes: (i) US$180 million in IDA credit and (ii) US$25 million in Global Financing Facility (GFF) Essential Health Services grant. The HBF development partners are expected to contribute US$163 million (or 7 percent) through parallel financing. The balance will largely be financed from the government, although a portion will be financed through other sources of domestic financing and on-budget support by development partners. The sources of program financing are summarized in Table 2.

Table 2. Program Financing

Source	Amount (US$ millions)	Percent of Total
Government budget	1,862	79%
IDA credit	180	8%
GFF Essential Health Services grant	25	1%
Health Basket Fund	163	7%
Other sources	118	5%
Total Program Financing	**2,347**	**100%**

10. **KRA 1. Maternal and child health services**. This results area aims to scale up provision of essential health services with a focus on RMNCAH-N services based on the defined list of evidence-based and cost-effective interventions at the PHC level, i.e., dispensaries, health centers and district hospitals. The interventions include: (i) ensuring PHC health facilities provide appropriate emergency obstetric care for the level; (ii) expanding coverage of newborn care; (iii) ensuring pregnant women receive appropriate package of ANC services for early detection and management of complications; and (iv) scaling up post-partum family planning as well as use of long-term family methods. Besides scaling up Maternal and Perinatal Deaths Surveillance and Response (MPDSR), the PHC facilities are to conduct routine continuous quality improvement activities building on star rating assessment and supervision findings. Furthermore, PHC facilities will be facilitated to oversee the community health workers (CHWs) and to network with schools in the provision of adolescent health services in their catchment areas, and in the process institutionalize management of the community-based health care programs within the PHC facilities. An important part of the planning process involves assessment of the health facility plans to ensure consistency with priorities as guided by PORALG and the MoH. The health facility

plans will cover operational costs including costs for outreaches, medical supplies, and basic medical equipment from Medical Stores Department (MSD) or the selected prime vendors, minor repairs, allowances to staff including the CHWs, vehicle use and maintenance, and referral services.

11. **KRA 2. Human resources for health**. This results area aims to improve availability of skilled health workers at the PHC level and selected regional referral hospitals, which is a key element in ensuring the quality of RMNCAH-N services. The interventions include: (i) recruitment and equitable deployment of health workers with a focus on PHC facilities; (ii) training priority staff, especially cadres in short supply, both clinical and nonclinical through short and long-term courses in the country; (iii) strengthening capacity of selected health training institutions to conduct competency-based trainings in RMNCAH-N; and (iv) clinical mentorship, coaching and attachment of newly recruited health workers in relevant aspects of RMNCAH-N service delivery with emphasis on emergency obstetrics and newborn care. Selected health training institutions will update their curricula, acquire teaching materials including books and equipment, and establish skills laboratories where necessary, while nine will be refurbished.[2] The MoH as the entity responsible for the health training institutions will carry out an assessment to establish the capacity building and refurbishment needs and develop a detailed plan of activities for each selected training institution. For each institution, the plans will cover the key activities including (a) design, (b) environmental and social impact assessment, (c) clearances from the National Environment Management Council (NEMC), (d) contracting arrangements, (e) actual works, (f) supervision of works and (g) capacity building activities (curriculum review process, recruitment of tutors and procurement of equipment and training materials).

12. **KRA 3. Emergency and referral services**. The results area aims to improve referral services and management of emergencies, especially in relation to those related to obstetric and neonatal care, though encompassing relevant cases in general. The interventions include: (i) enhancing capacity of selected regional referral hospitals to handle referrals and emergencies including managing critically ill patients in accordance with established standards and (ii) establishing reliable systems for communication and transport to coordinate and manage referrals between communities, PHC facilities and regional referral hospitals. Under the KRA, selected regional referral hospitals are to be equipped and refurbished to handle emergencies including establishing appropriate neonatal units and satellite blood banks to facilitate provision of safe blood and blood products and expand use of electronic medical records (EMRs). To this effect, a plan will be prepared identifying specific capacity building and refurbishment related activities for each of the selected regional referral hospitals including activities on the design, environmental and social impact assessment, NEMC approval, contractual arrangements, actual works, and supervision of works.

13. **KRA 4. Health facility performance and functionality.** This results area will support activities to improve performance and functionality of selected PHC facilities as per the recommended service delivery standards. In addition to improving the status of infrastructure in selected PHC facilities, the KRA will primarily support recently refurbished facilities to become fully functional and able to deliver appropriate complement of services for their designated levels. For the selected dispensaries, this means performing signal functions for basic emergency obstetric and newborn care (BEmONC) while for the selected health centers, performing signal functions for comprehensive emergency obstetric and newborn care (CEmONC) would be the focus. The district hospitals, besides performing signal functions for comprehensive emergency obstetric and

[2] Sumbawanga COTC, Muheza COHAS, CEDHA, Tukuyu NTC, Mpwapwa EHS Training Centre, Mbulu NTC, Same NTC, Geita NTC, and Kahama NTC. The areas for refurbishment include lecture rooms, skill labs, libraries, staff houses, administration offices, and other facilities that would improve teaching and learning environments

newborn care will provide requisite services for managing referrals and emergencies and set up appropriate room/space to treat sick neonates including continuous positive airway pressure. The interventions include (i) ensuring availability of the necessary medicines, supplies and equipment; (ii) refurbishing selected health facilities as appropriate; (iii) providing health facilities with power, water, and sanitation, as appropriate; (iv) expanding use of EMRs in PHC facilities; and (d) promoting quality improvement activities by the PHC facilities. Solar power will be installed in PHC facilities without power grid connections and to provide backup power in selected rural PHC facilities as appropriate. Instead of the current approach where plans are prepared around technical programs, plans are to be built around improving operations of health facilities to promote their functionality. PORALG will carry out an assessment and prepare a report that will inform the development of the appropriate individual facility improvement plans. For the group of PHC facilities that will undergo refurbishment, the report will establish the areas for refurbishment per health facility which will guide the preparation of the individual facility refurbishment plans. The individual facility refurbishment plans will include activities related to design, environmental and social impact assessment, NEMC approval, contractual arrangements, actual works, and supervision of works.

14. **KRA 5. Management and Accountability**. This results area covers management and coordination functions required for the implementation of Program activities. The interventions include: (a) coordination and supervision of RMNCAH-N implementation at the LGAs and the PHC facilities; (b) strengthening fiduciary capacity of the LGAs and the PHC health facilities; (c) supporting Program management functions, including monitoring and evaluation, audits, financial management (FM), procurement, and verification; (d) capacity building activities necessary for execution of the Program; and (e) strengthening implementation capacity for environmental and social activities.

1.4 Program Development Objective(s) and PDO Level Results Indicators

15. The Program Development Objective (PDO) of the proposed PforR operation is to scale up the provision and improve quality of essential primary health care services with a focus on Maternal and Child Health Services

16. The PDO level results indicators are:

- Percentage of PHC facilities with continuous availability of 30 items (medicines, vaccines, medical devices) in the past year
- Percentage of dispensaries with at least two qualified/skilled health providers (nurse/midwife and clinical officer)
- Percentage of institutional deliveries
- Percentage of PHC facilities achieved 3 stars and above[3]

[3] The star rating tool assesses the performance of PHC facilities against four main domains: (a) health facility management and staff performance, (b) service charters and social accountability, (c) safe and conducive facilities, and (d) quality of care and services, which are further subdivided into 12 service areas: legal status, facility management, HMIS, staff performance, organization of services, emergency and referral system, client focus, social accountability, facility

- Percentage of newborns receiving postnatal care within 48 hours after delivery.

17. **Disbursement Linked Indicators and Verification Protocols**: A set of eight disbursement-linked indicators (DLIs) plus eight sub-DLIs will form the basis for disbursements under the Program. The DLIs correspond to the KRAs and address the major bottlenecks constraining delivery of essential PHC services including referral services in Tanzania. The DLIs were chosen taking account of the mandates of the implementing entities and reflect priority actions from all levels of the health system (national, regional and district) to promote the delivery of PHC as well as referral services. The DLIs comprise a combination of actions and outputs and will be disbursed on annual and scalable bases. In addition, undisbursed financing allocated to a DLI each year can be rolled over to the subsequent years upon achieving expected results subject to not exceeding the DLI allocation and/or disbursement cap. The DLIs are summarized in Table 3 while the Disbursement Linked Results (DLRs), allocations, and disbursement and verification protocols are included in Annex 2 of the PAD.

Table 3: Summary of Disbursement Linked Indicators

Key Results Area	Disbursement Linked Indicators	Disbursement frequency	US$ M
Maternal and child health services	DLI 1. Improved annual delivery of maternal and child health services by the LGAs	Annual	IDA: 61 GFF: 20
	DLI 2. Improved annual performance of central and regional entities in supporting the LGAs to deliver PHC services	Annual	IDA: 9
Human resources for health	DLI 3. Increased capacity for training health institutions	Annual	IDA: 11
	DLI 3.1. Number of HRH who have received mentorship, coaching and attachment		IDA: 8
	DLI 3.2. Number of students sponsored for priority courses with a focus on MCH		IDA: 6
	DLI 4. Increased availability of skilled staff at the PHC facilities	Annual	IDA: 6
Emergency and referral services	DLI 5. Number of regions with established referral services	Annual	GFF: 5
	DLI 5.1. Increased number of referral cases managed through the established referral and emergency systems by the regions		IDA: 5
	DLI 6. Number of selected RRHs with approved capacity building and refurbishment plans	Annual	IDA: 1
	DLI 6.1. RRHs have reached key milestones in the implementation of individual refurbishment plans		IDA: 18

infrastructure, infection prevention and control, clinical services and clinical support services. The service areas are rated on a scale of 1 to 5 stars.

	DLI 6.2. Increased number of RRHs that have completed implementation of the approved capacity building plans		IDA: 6
	DLI 6.3. Increased number of emergency and referral cases managed by the RRHs		IDA: 3
Health facility performance and functionality	DLI 7. LGAs that have refurbished selected PHC facilities as per the approved plans	Annual	IDA: 22
	DLI 7.1. PORALG has procured the medical equipment and deployed them to the PHC facilities as per the procurement plan		IDA: 8
	DLI 7.2. Increased number of PHC facilities (dispensaries, health centers and district hospitals) that are functional and meet the requisite standards		IDA: 5
Management and accountability	DLI 8. Improved management and accountability	Annual	IDA: 11

18. **DLI 1. Improved annual delivery of maternal and child health services by the LGAs**. This DLI is aligned with KRA 1 on MCH services and reflects the performance of LGAs in scaling up delivery of RMNCAH-N services that meet the requisite service delivery standards. The performance of the LGAs will be assessed annually using an average LGA score card based on a set of 10 criteria comprising 6 RMNCAH-N services delivery criteria and 4 health systems strengthening criteria targeted towards improving quality of care. Annual disbursement for this DLI will take place when the LGAs achieve a minimum average score of 60 percent for the selected indicators.

19. **DLI 2. Improved annual performance of central and regional entities in supporting LGAs in the delivery of PHC services**. This DLI is aligned with KRA 1 on MCH services and reflects the performance of the MoH and PORALG at the center and the RHMTs in facilitating delivery of health services by the LGAs and PHC facilities. Their performance will be assessed annually using an average score card based on a set of 4 criteria which reflect core actions by the central and regional level entities in facilitating health services delivery by the LGAs.

20. **DLI 3. Increased capacity to train and mentor HRH.** This DLI is aligned with KRA 2 on HRH and is aimed at strengthening the capacity of relevant institutions responsible for the development of the health workforce. The results under the DLI reflect (i) development and execution of appropriate plans to address critical capacity constraints affecting selected health training institutions in carrying out competency-based trainings in RMNCAH-N; (ii) initiatives on mentorship, coaching and attachment of newly recruited staff; and (iii) training priority staff, especially those in short supply through short and long-term courses in the selected health training institutions. The DLI will be assessed against progress with implementation of the plans. For each health training institution, the plans will consider availability of tutors; curriculum revision process; acquisition of teaching materials, books, and equipment; establishment of skills laboratories; and refurbishments.

21. **DLI 4. Increased availability of skilled staff at the PHC facilities**. This DLI is aligned with KRA 2 on HRH and is aimed at increasing availability of skilled health workers at the PHC facilities. The results under the DLI reflect actions on recruitment and deployment of health workers on a two-year contract in the PHC facilities with most staff deployed in the dispensaries.

22. **DLI 5. Increased number of regions with established referral services**. This DLI is aligned with KRA 3 on emergency and referral services. It is aimed at the development and expansion of a system for management of emergencies and referrals built around the regions.

23. **DLI 6. Enhanced capacity of selected regional referral hospitals to manage emergencies and referrals**. This DLI is aligned with KRA 3 on emergency and referral services. It aims to enhance the capacity of selected regional referral hospitals to handle referrals and emergencies and treat critically ill patients as per the existing clinical standards of practice. The results under the DLI reflect the development and implementation of the plans to equip, refurbish and improve quality of services in selected regional referral hospitals. Each selected regional referral hospital will develop a plan whose implementation will be assessed against achievement of the key implementation milestones over the duration of the operation. The MoH is responsible for overseeing the regional referral hospitals and will coordinate implementation of the activities.

24. **DLI 7. Improved performance and functionality of PHC facilities.** This DLI is aligned with KRA 4 on health facility performance and functionality and is aimed at tackling performance gaps to improve performance and functionality of selected PHC facilities in delivering health services that meet the designated standards. The results for PHC facilities to undergo refurbishment will be measured against achievement of the key milestones for the implementation of the individual facility refurbishment plans while the results for the second category of PHC facilities will be measured by increase in the number of health facilities that are able to perform the requisite signal functions for emergency obstetric and newborn care.

25. **DLI 8. Improved management and accountability**. This DLI is aligned with the KRA on management and accountability. The DLRs are about management and capacity building activities necessary for the coordination and implementation of the Program. The DLR under the MoH includes activities on (i) implementation of annual reproductive and child health coordination and supervision activities; (ii) implementation of annual plan of activities for Program management including verification, audits (financial and procurement), monitoring and evaluation, and environmental and social management; (iii) implementation of annual capacity building activities; (iv) institutionalization of the star rating assessment and support for continuous quality improvement activities. It is envisaged that at least two rounds of the star rating assessment will be conducted during the operation's duration. The DLR under PORALG includes activities on (i) implementation of annual plan of activities for Program management including monitoring and evaluation and environmental and social management; (ii) implementation of annual capacity building activities; (iii) implementation of activities on social accountability at the LGAs and PHC facilities; and (iv) assessment of PHC facility plans for consistency with agreed priorities.

26. ESSA analyzed the environmental and social management system for the Programmme to assess the applicability of each of the Core Principles and ensure consistency with those that apply. The gaps identified through the ESSA and actions recommended to fill those gaps which are expected to directly contribute to the Programme's anticipated results in the Health sector.

27. This Report presents an analysis of the existing system vis-à-vis the relevant Core Principles for environmental and social management in the Bank Policy and Bank Directive as revised in 2022, and an Action Plan that will be incorporated into the overall Program financing.

1.5 Development Partners

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

1.6 Expected Program Key Results

29. Key Programme results indicators include the following: (reduced to five and disaggregate for inequality).
    i. Percentage of women of reproductive age (15-49 years) using modern family planning methods
    ii. Percentage of PHC facilities with continuous availability of essential medicines and supplies in the past quarter.
    iii. Proportion of mothers who received 2 doses of intermittent preventive therapy (IPT) for malaria during last pregnancy; antenatal care (ANC) attendees receiving recommended quantity of iron and folic acid tablets
    iv. Percentage of LGAs with functional emergency and referral system
    v. Percentage of institutional deliveries

SECTION II: EXPECTED ENVIRONMENTAL AND SOCIAL EFFECTS OF THE RMNCA-HS PROGRAM AND EXCLUSION CRITERIA

2.1 Introduction

30. The project investment, which is a P4R Programme, aims to scale up the provision of essential primary healthcare services and improve their quality, with a focus on Reproductive Maternal Neonatal Child and Adolescent Health-Nutrition (RMNCAH-N) Services. The interventions under the Programme include expansion of the provision of health services, construction and renovation of health facilities including but not limited to providing health facilities with the appropriate facilities for power, water, and sanitation, HCWM, and procurement with subsequent use of medical equipment and products (medicines and supplies) associated with environmental, and social risks and impacts as elaborated below:

2.2 Environmental Impact during Construction / Renovation of Health Facilities

31. Air, Soil and Water Pollution: Construction or renovation of health facilities is likely to cause environmental and social risks and impacts related to air, land, water, and dust pollution especially during the construction period. Pollution will be caused by the generation of construction wastes which might find their way into the soil, water bodies and air.

Impacts caused by the Noise Pollution: The construction activities will involve the use of heavy machinery and trucks which will result in noise and vibration. Excessive noise can impair the hearing of construction workers while the vibration may result in damage to other nearby buildings which can include community structures if any. In addition, noise and vibration can lead to annoyance and impacts on the wellbeing of workers and people surrounding the construction site.

Impacts caused by erosion and loss of vegetation: In some few cases construction might cause loss of vegetation due to clearing of land. Removal of soil cover will expose the remaining area to runoffs, which may result in soil erosion in return. Inadequate backfilling and resurfacing may result into erosion which may damage the constructed structures and may result in siltation of the receiving water bodies. However, this will happen at a very limited scale because most of sub investments will be confined within health facilities land.

2.3 Potential Social Risks and Impacts during Construction, Renovation of Health Facilities

32. The anticipated social risk and impacts include GBV, sexually transmitted diseases (STDs), spread of Covid-19 virus, violation of workers' rights, and land take leading to displacement of people and economic activities as detailed below:

GBV, SEA, and STDs: The presence of non-local and local workers for the civil works under RMNCAH-N could exacerbate the risk of GBV, sexual harassment and/ or other sexual offenses including rape. The situation might be complicated given the wide scope of the project, covering several regions in the country where GBV cases are prevalent. Construction workers may engage in sexual fraternization and transactional sex with younger women and girls. This can contribute to the spread of Sexually Transmitted Diseases (STDs) including HIV/AIDS and may result in unexpected pregnancies. Similarly, it can lead to domestic conflicts, GBV and domestic violence at the household level. Also, women seeking for employment in the project may sexually harassed by being forced to give sexual favours to men who are responsible for recruiting workers. Once employed, women may continue being

victims of sexual exploitation as those who have given them jobs may keep demanding for sexual favours from them by threatening to dismiss them on refusal to fulfil their demands or by denying them other benefits or opportunities such as overtime. Furthermore, female workers may also be vulnerable to being sexually assaulted by their male colleagues. In order to address all these potential social risks, RMNCAH-N will devise mechanisms for protecting both the local population and civil workers against GBV and SEA.

COVID-19 Risks and Impacts: Projects involving construction/civil works normally make use of a large work force, apart from those who will be responsible for supplies, supporting functions and services. The work force may comprise workers from national and local labor markets. They may need to live in on-site accommodation, lodge nearby the work sites or return to their homes after work. Given that there will be many workers coming into the communities, and medical facilities to execute the construction activities related to the project, the chance for spreading communicable diseases such as COVID-19 is going to be high. Given such a situation, the Program will develop a set of principles and minimum standards meant to serve as measures against the spread of COVID-19. This will include but not limited to:

- Adherence to the rules and regulation guidelines set by the Government of Tanzania;
- Taking all necessary precautions to maintain the health and safety of the Personnel involved in the program;
- Ensuring suitable arrangements are made for all necessary welfare and hygiene requirements and for the prevention of epidemics at all sub-project sites;
- The personnel will be encouraged to use the existing project grievance mechanism to report concerns related to COVID-19, preparations made by the program/sub-projects to address COVID-19 related issues, how procedures are being implemented, and concerns about the health of their co-workers and other staff; and
- All Government protocols of health and safety are met at all Program intervention areas.
- Following the guidelines set out in the WB's ESF/Safeguards Interim Note: COVID-19 Considerations in Construction/Civil Works Projects, issued on April 7, 2020

Forced and Child labour: The use of forced labour within the project is unlikely to happen since construction workers will be employed on the basis of standard contracts. Furthermore, the firms and contractors to undertake the construction activities are selected based on their skills and qualifications by taking into account their diligence on labour and working conditions. However, employment of children by contractors might occur as child labour is known to exist in the construction industry in Tanzania.

Violation of Workers' Rights: Construction / renovation staff tend to be victims of exploitation and unfair treatment by employers including long working hours, irregular payments, lack of rest periods, payments, and lack of contracts. Unskilled and semi-skilled workers, unlike the skilled ones, may lack knowledge of their rights or be willing to waive these rights just for the mere sake of securing employment.

Health and Safety Hazards: The construction/renovation of health facilities will involve civil works that might cause health and safety hazard risks such as accidents to workers. The occupational health and safety issues to be associated with the construction of the proposed project include physical, chemical, noise and health hazards. Some of the project construction activities will involve handling of potentially harmful

objects, working at heights, transporting construction materials from the source to the project site, lifting of heavy equipment, vehicular traffic, contact with electrical conductors, exposure to dust, and excessive noise. Thus, the construction workers will be vulnerable to cuts, fractures and electrical shocks, and ailments from harsh ambient effects and unsanitary conditions. These are significantly negative impacts.

Accidents and Emergencies: Accidents, fire, and emergencies could also occur during the construction, renovation, and operation of the regional statistics offices. As described under the health and safety section, accidents and emergencies may be caused by handling of potentially harmful objects, working at heights, lifting of heavy equipment, vehicular traffic and contact with electrical conductors. Workers will also be subjected to injuries caused by falls, cuts, fractures, electrical shocks, ailments from harsh ambient effects and unsanitary conditions.

Physical and Economic Displacement: Although land take is not expected in this program since much of the work will be confined within the existing health facilities, in some cases where expansion of health facilities is necessary, appropriation of land from the community or households for a range of uses (housing, economic activities, businesses, etc.) may occur. Where land is acquired or donated, the result will be loss of livelihood and household incomes.

2.4 Environmental Impacts during Operational Phase

33. Generation of Health Care waste: The RMNCAH-N) Services will expand essential primary health care services which will increase the generation of health care waste (HCW). HCW has a higher potential of causing infection and injury compared to other types of wastes. Hence inappropriate HCW management may result into serious consequences on public health and the environment. In Tanzania, the HCW management program is seriously under-resourced (manpower and funds), something which prevents it from providing satisfactory oversight. Incinerators found in the hospitals have no capacity to properly dispose wastes, which means they have weak efficiency. During consultation with various stakeholders, it was revealed that many of those incinerators have capacities below the standard, do not perform well and cannot capture emissions, except one in Itigi Hospital in Singida.

Increased Generation of Liquid Wastes: The RMNCAH-N project is likely to increase generation of liquid waste from improved health facilities which may contain contaminants thus threatening public health. The situation is complicated by limited capacity to manage wastes and limited awareness of environmental health risks associated with poor quality of water, inadequate sanitation and poor hygiene. Training on the roles and responsibilities of the Councils is usually provided to the committees, but not to the community they serve due to financial constraints.

Fire outbreak: During the project operation, the facilities will be connected to the national grid electricity (TANESCO). So, improper wiring system, use of electrical equipment that is not up to the recommended standards, and poor handling of kitchen gas cylinders may lead to overheating at the project site. The impact of this may be loss of lives and properties around the project area. This is considered a negative long-term impact with high significance.

The aforementioned environmental and social risks and impacts along with their associated mitigation measures and risk ratings are detailed in Table 4 below.

Table 4: Risks and Impacts, Mitigation Measures and Guidance on Policy and Legal Framework

No.	Risk description	Risks rating	Risk Impact Management (Recommendations for Mitigation Measures)	Recommended Policy and Legal Framework
1.	Generation of construction waste, air, soil and water pollution during construction or renovation of health facilities.	Moderate	o Prepare Site Specific Environmental and Social Management Plan (ESMP). o Make use of dust suppressive agents e.g. water; o Compact the excavated soils to reduce the amount of dust spread by wind o Clean all contaminated sites after completion of civil works.	National Environmental Policy, 2021 EMA (2004) EIA & EA Regulations, 2018, Hazardous Waste Regulations, 2019
2.	Noise Pollution during construction and rehabilitation activities.	Moderate	o Limit noisy activities to day time. o Cary regular vehicle maintenance as per manufacturer	National Environmental Policy, 2021 EMA (2004); EIA & EA Regulations, Hazardous Waste Regulations, 2019
3.	Soil erosion and loss of vegetation	Low	o Compact the excavated soils to reduce the amount of dust spread by wind o Grassing o Limit vegetation cutting where possible	National Environmental Policy, 2021; EMA (2004); Hazardous Waste Regulations, 2019
4.	o Further spread of HIV/AIDs, STDs & COVID-19 cases. o Increase in Gender Based Violence and Sexual Exploitation and Abuse cases	Moderate	o Develop and Operationalize the Workers' code of conduct including GBV/SEA prevention and response. o Mainstream Ministry of Health COVID-19 Management Protocol in all civil works and public consultation and engagement. o Enhance existing mechanisms for grievance redress and complaint handling.	o HIV and AIDS (Prevention and Control) Act of 2008 o National Plan of Action to End Violence against Women and Children in Tanzania 2017/8-2021/2 (NPA-VAWC 2017/18 – 2021/22). o Ministry of Health (MoH) Guideline on How to Manage the Spread of Covid-19 at

				Schools, Colleges, Universities and Other Education Institutions, the Second Edition July, 2021. o Ministry of Health (MoH) Guideline on How to Manage the Spread of Covid-19 through Intervention of Control of Public Gathering without Affecting Economic Activities, Second Edition, July 2021.
5.	Forced and Child labour and Violation of Workers Rights	Low	Maintain effective collaboration with the Ministry of Labour and Employment on labor management issues.	o Employment and Labour Relations Act No. 6 of 2004. o Law of the Child Act No. 21 (2009).
6.	o Occupational Health and Safety Hazards risks during construction/renovation of health facilities o Accidents and Emergencies related to fire and handling of potentially harmful objects, working at heights, lifting of heavy equipment, vehicular traffic and contact with electrical conductors.	Moderate	o Maintain effective collaboration with OSHA on occupational health and safety issues. o Encourage proper handling of potentially harmful objects o Tool Box talk o Proper insurance of Personal Protective Equipment (PPE)	o EMA, 2004 o The Occupational Health and Safety Act No. 5 of 2003 o The Occupational Health and Safety (First aid and Welfare Facilities) Rules, 2015
7.	Physical and economic displacement that might be associated with land take where expansion of health facilities is necessary.	Low	o Confine construction/rehabilitation within institutional land o When the former is not feasible compensate PAPs.	o Land Act No. 4 of 1999 and Village Land Act No. 5 of 1999; o Land acquisition Act 1967, o Land (Assessment of the Value of Land for Compensation) Regulation 2001, o Land (Compensation Claims)

				Regulations, 2001 and o Guidelines for Valuation and Compensation), 2016. *(Mwongozo wa Uthamini wa Fidia)*
8.	Increased generation of Health Care waste (HCW) due to expansion of essential primary health care services.	High	o Updated technical guidelines on HCW management o Operationalize technical guideline for HCW management o C o Enhance the capacity and management of selected incinerator management, o Enhance occupational safety and hygiene practices.	o EMA (2004) o National Policy Guidelines for Health Care Waste Management in Tanzania (2017). o Public Health Act (2009) o The National Strategic Plan for Health Care Waste Management (2018 -2022). o Generic Waste Management Guidelines (2015) o Hazardous Wastes (Control and Management) Regulations (2019)
9.	Increased generation of liquid wastes which may contain contaminants.	High	o The Improved Health Care Facilities to include appropriate destination wastewater treatment e.g. septic tanks or connection to sewerage systems. o The designs of health facilities to include drawings and designated areas to accommodate liquid wastes.	
10.	Risk of air pollution/air quality impacts from incinerators during operational phase	Moderate	o Enhance management of incinerators. o Put in place Operation &Maintenance Plan for incinerators.	

2.3 Exclusion Criteria

34. The exclusion principle applies to Program activities that meet these criteria, regardless of the borrower's capacity to manage such effects. In the PforR context, the concept of exclusion means that an activity is not included in the identified program of expenditures. An activity is not included if it requires completion of a non-eligible activity to achieve its contribution to the Project Development Objective

(PDO) or any specific Disbursement Linked Indicators (DLI). The six principles under the PforR will apply to all investments as a mechanism for mitigating adverse environmental and social impacts.

The program shall exclude projects that are likely to cause:

- Significant conversion or degradation of critical natural habitats or cultural heritage sites.
- Air, water, or soil contamination, leading to adverse harm on the health or safety of individuals, communities, or ecosystems.
- Workplace conditions that expose workers to significant health and personal safety risks.
- Land acquisition and/or resettlement of a scale or nature that will have significant adverse impacts on affected people or the use of forced evictions.
- Large-scale changes in land use or access to land and/or natural resources.
- Adverse E&S impacts covering large geographical areas, including transboundary impacts, or global impacts such as greenhouse gas (GHG) emissions.
- Significant cumulative, induced, or indirect impacts.
- Activities in which forced or child labour is engaged.
- Marginalization of some groups, or conflict within or among social groups.
- Activities with high risk of GBV and SEA.

As per the PforR financing Environment and Social Systems Assessment Guidance of July 2019, resettlement involves physical relocation of individuals and communities followed by acquisition of land for programme purposes. Because of the extreme sensitivity of land acquisition and resettlement, the Bank takes caution while engaging in any resettlement when the borrower cannot demonstrate that its systems meet the core principles and attributes or cannot ensure consistent satisfactory resettlement outcomes. It is not necessarily helpful to define fixed numerical thresholds for "large scale" because the significance of impacts depends very much on local contextual factors. The definition of significant resettlement impacts is closely related to the extent to which the borrower's systems align with the core principles and to the borrower's capacity to carry out land acquisition and resettlement in accordance with policy principles and requirements. Emphasis should be on the potential for significant impacts on the affected people regardless of scale since significant adverse impacts are not acceptable to the Bank even if they affect only a small number of people. When the Bank team's assessment finds that the borrower is not able to demonstrate resettlement practices consistent with the PforR core principles, regardless of the size or severity of resettlement impacts, the PforR operation should proceed only after a separate review of agreed resettlement systems and capacity-building actions.

Activities that would (a) have adverse impacts on land and natural resources subject to traditional ownership or under customary use or occupation; (b) cause relocation of VMGs from land and natural resources that are subject to traditional ownership or are under customary use or occupation; or (c) have significant impacts on the cultural heritage that is essential to the identity and/or cultural, ceremonial, or spiritual aspects of the affected communities, are excluded from the PforR program.

Risk Rating: Taking into consideration the potential risks and impacts of the RMNCAH-N) Services and the fact that Project components are expected to be implemented mainly within the existing government-owned facilities, there is low to moderate likelihood that the program activities will lead to significant E&S

consequences. The risks are well understood and it is assumed that, the E&S outcomes can be sustainably managed, augmented with capacity-building measures. Overall, the risk rating is set at Substantial.

2.4 Grievance Redress Mechanisms

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

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

- LGAs have a complaint box for receiving complaints and, depending on the issues raised, either provide resolutions or include the received complaints in the community score card for mutual discussions and addressing.
- Village Health Committees also have a similar mechanism for handling complaints. They respond to the complaints or forward them to the next higher level for redress if they are beyond their jurisdiction
- Health centers and district hospitals governing committees are responsible for receiving and handling complaints.

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

World Bank Grievance Redress System

Communities and individuals who believe that they are adversely affected by the World Bank (WB) supported project may submit complaints to existing project-level grievance redress mechanisms or the WB's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed to address project-related concerns. Project-affected communities and individuals may submit their complaint to the WB"s independent Inspection Panel which determines whether harm occurred or could occur, as a result of WB's non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been allowed to respond. For information on how to submit complaints to the World Bank's Corporate Grievance Redress Service (GRS), please visit http://www.worldbank.org/GRS. For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.

SECTION III: ESSA SCOPE AND METHODOLOGY

36. To prepare the ESSA RMNCAH -N the following activities were undertaken:

a) *Review of the relevant Policies, Legal Framework, Regulations, Program Documents, and guidelines* and analyzed for consistency with the Bank Policy and Bank Directive (BP&BD) for PforR program.

- The review examined the set of policies and legal requirements related to environmental and social management at the national and regional government level. The review also examined technical and implementation support documents from previous and ongoing World Bank PforR programs.
- Review and assessment of the institutional roles, responsibilities, and coordination and analysis of current capacity and performance in carrying out those roles and responsibilities.
- Consideration of public participation, social inclusion, and grievance redress mechanisms.

b) *Assessment of the potential environmental and social risks of the RMNCAH -N financing activities.*

c) *Undertaking site/field visits.* The ESSA team conducted field visits to various primary health care centers and dispensaries.

d) *Preparation of environmental and social inputs to the Program Action Plan.*

e) *Meeting and discussion with implementing institutions and other relevant partners.*

f) *Multi-stakeholders Consultations:* The consultations were attended by participants from Academic Institutions; Healthcare practitioners; Donors, International NGOs & local NGOs dealing with health; organizations dealing with people who have disabilities; and Government officials, Regulatory authorities and Ministries.

g) **Analysis:** The ESSA assessed the overall system for environmental and social impact management that will be applied to the PforR operation, which focuses on improving service delivery, strengthening systems, and financing civil works related to upgrading and improvement of infrastructural conditions and utility services in health facilities.

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

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

institutional capacity to implement the system as demonstrated by performance, thus far. Specifically, the ESSA focused on assessing and documenting the following:

i. The adequacy of institutional organizations and division of labor, and the likelihood that the applicable E&S management systems can meet their goals;
ii. Internal review and clearance procedures such as licensing, stakeholder involvement in planning and implementation, supervision oversight, monitoring and evaluation;
iii. The adequacy of institutional capacity (staff, budget, availability of implementation resources and equipment, training, etc.) to carry out defined responsibilities under the applicable Program system;
iv. The effectiveness of interagency coordination arrangements where multiple agencies or multiple jurisdictions are involved;
v. The performance of the Implementing Agency in ensuring that the rules and procedures are being followed.

The analysis presents findings on whether the current system: (i) mitigates adverse impacts; (ii) provides transparency and accountability; and (iii) performs effectively in identifying and addressing environmental and social risks. The overarching objectives are to ensure that the risks and impacts of the Program activities are identified and mitigated, and to strengthen the system and build the capacity to deliver the Program in a sustainable manner. This ESSA report also proposes measures to strengthen the system.

3.1 Disbursement-Linked Indicators

37. A set of Disbursement-linked Indicators (DLIs) for the Program will form the basis of disbursement. The use of such DLIs is expected to sharpen the Program by sending a signal to key stakeholders to focus on critical results. The following principles were applied in the process of selecting these DLIs:

a. maximizing the use of existing indicators in the government's program, especially those in HSSP IV and BRN;
b. corresponding to the key priority areas of PHC in HSSP IV; especially the major bottlenecks along the results chain and providing incentives for removing them;
c. stimulating performance at all levels of the system: national, regional, LGA and PHC facility;
d. prioritizing the use of the government routine information system (e.g. DHIS2) and the existing reporting mechanisms (e.g., RMNCH scorecard) for sustainability
e. balancing ambition ("stretch") and feasibility ("realism");
f. taking into account a reasonably even distribution of disbursements; and,
g. Where applicable, undisbursed amount of IDA financing for a DLI in a given year will be rolled-over for use in subsequent years.

38. There is a total of 8 DLIs, out of which five are composite with sub-criteria. They are a combination of actions, intermediate outputs, and output. DLI 1 ensures that a robust framework for the Program has been established. The rest, DLIs 2-8, form a chain of PHC-related accountability and performance at all levels in the system (Figure 1).

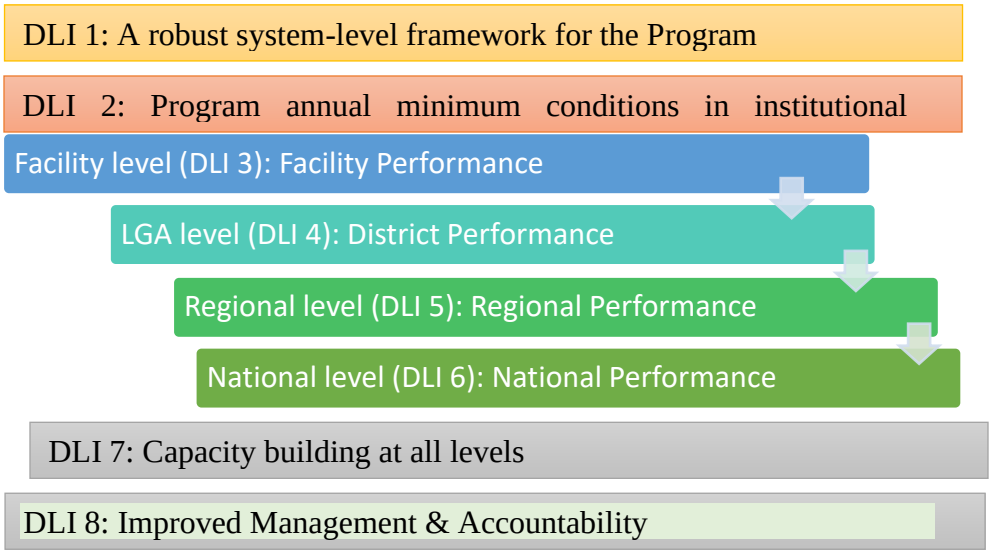


Figure 1: Eight DLIs forming a cascade of PHC-related accountability and performance

39. Table 5 below summarizes the 8 DLIs. It should be noted that as DLIs 4, 5, 6, 7 and 8 follow the N+1 principle (pay for the performance of the previous year), there will be no disbursement against them in Year 1. (See Annex V for details on the DLIs).

Table 5: Summary of Disbursement Linked Indicators

Priority Area	***DLIs***	***Annual Indicative Attainment Schedule***					**Disbursement frequency & approach**
		YR 1	YR 2	YR 3	YR 4	YR 5	
	DLI1: Recipient has completed all foundational activities	X	X				By each sub activity upon achievement
Institutional Performance at all levels	DLI 2. Recipient has achieved all of the Program minimum annual conditions in institutional strengthening at all levels (national, regional, LGA and facilities)	X	X	X	X	X	Annual All-or - nothing
Performance at facility level	DLI 3. PHC facilities have improved Maternal, Neonatal and Child Health service delivery and quality as per verified results and received payments on that basis each quarter	X	X	X	X	X	Quarterly Sliding scale
Performance at LGA level	DLI 4. LGAs have improved annual Maternal, Neonatal and Child Health service delivery and quality as measured by the LGA Balance Score Card		X	X	X	X	Annual Sliding scale

Priority Area	*DLIs*	*Annual Indicative Attainment Schedule*					Disbursement frequency & approach
		YR 1	YR 2	YR 3	YR 4	YR 5	
Performance at regional level	DLI 5 Regions have improved annual performance in supporting PHC services as measured by Regional Balance Score Card		X	X	X	X	Annual Sliding scale
Performance at national level	DLI 6. MoHCDGEC and PO-RALG have improved annual PHC service performance as measured by the National Balance Score Card		X	X	X	X	Annual Sliding scale
Capacity building	DLI 7. Completion of annual capacity building activities at all levels		X	X	X	X	Annual Sliding scale
Management & Accountability	DLI 8: Improved Management & Accountability		X	X	X	X	Annual Sliding scale

SECTION IV: ESSA OBJECTIVE, CORE PRINCIPLES, RISKS SCREENING

4.1 Objectives and Scope of the ESSA

40. An Environmental and Social Systems Assessment (ESSA) was undertaken by the Bank team for the Program as per the requirement set forth under the Program for Results Financing Operations. The ESSA reviewed the capacity of the existing Tanzania government (national and provincial) systems to plan, implement effective measures, monitor and report on environmental and social risks and impact management for the program, including finding out if there are measures which require strengthening. This involved assessing the environmental and social systems in place, the human resources, the competencies, the gaps /weaknesses, the extent and nature of necessary improvements, and the risks plus the related mitigation measures that would form the basis for a Program Action Plan (PAP).

Specific Objectives of ESSA are to:

(a) Support the design and implementation of E&S aspects for PforR operation to enhance borrower systems, capacity and performance
(b) Identify the potential environmental and social impacts/risks associated with the Program interventions,
(b) Review the policy and legal frameworks related to the management of environmental and social impacts of the Program interventions,
(c) Assess the institutional capacity for environmental and social impact management within the Program system,
(d) To prescribe institutional arrangements for the identification, planning, design, preparation and implementation of the sub-projects under the proposed program to adequately address environmental and social sustainability issues,
(e) Specifying appropriate roles and responsibilities and outline the necessary program management and reporting procedures for managing and monitoring environmental and social concerns related to the proposed program,
(f) Assessing the consistency of the Borrower's systems with six core principles and attributes defined in the Bank's Policy – Program for Results Financing, to include assessment of monitoring and evaluation systems for environmental and social issues,
(g) To describe actions to fill the gaps identified, which will be put into the Program Action Plan to strengthen the Program's performance in relation to the core principles of the PforR instrument.

4.2. ESSA Core Principles

41. The ESSA was conducted to ensure consistency with the six "core principles" outlined in paragraph 8 of the World Bank's policy on how projects under the Program-for-Results Financing should effectively manage Program risks and promote sustainable development. The six core principles are:

Core Principle 1: Program E&S management systems are designed to (a) promote E&S Sustainability in the Program design; (b) avoid, minimize, or mitigate impacts; and (c) promote informed decision-making related to a Program's E&S effects.

Core Principle 2: Program E&S management systems are designed to avoid, minimize, or mitigate adverse impacts on natural habitats and physical cultural resources resulting from the Program. Program

activities that involve the significant conversion or degradation of critical natural habitats or critical physical cultural heritage are not eligible for PforR financing.

Core Principle 3: Program E&S management systems are designed to protect public and worker safety against the potential risks associated with (a) the construction and/or operation of facilities or other operational practices under the Program; (b) exposure to toxic chemicals, hazardous wastes, and otherwise dangerous materials under the Program; and (c) reconstruction or rehabilitation of infrastructure located in areas prone to natural hazards.

Core Principle 4: Program E&S systems manage the land acquisition and loss of access to natural resources in a way that avoids or minimizes displacement and assists affected people in improving, or at the minimum restoring their livelihoods and living standards.

Core Principle 5: Program E&S systems give due consideration to the cultural appropriateness or and equitable access to, Program benefits, giving special attention to the rights and interests of Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities, and to the needs or concerns of vulnerable groups.

Core Principle 6: Program E&S systems avoid exacerbating social conflict, especially in fragile states, post-conflict areas, or areas subject to territorial disputes.

4.3 Integrated Risk Assessment

42. Based on the findings of the ESSA Analysis, Table 6 below aggregates the risks (*according to, four criteria for risk screening: likely E&S effects, contextual risk factors, institutional capacity & complexity risks, and reputational & political risks*); and the measures proposed for mitigating those risks. These are included in the Program's integrated risk assessment.

Table 6: Integrated Risk Assessment

Risk Description	Risk Management
Criteria 1: Likely E&S effects	
Potential Impacts of identified, Monitored; Program scope includes construction or large civil works. Environmental and Social Programmes are not mitigated, and is changed to scale	Overall, the potential environment and social risks of the Program are site-specific, moderate, straightforward and manageable, related primarily to construction management, occupational health and safety, construction and healthcare wastes. While technical guidelines and standards exist, inadequate capacity and insufficient resources (Human and funds) can result in poor implementation, inadequate enforcement and monitoring, whose outcome would be poor mitigation of potential impacts.
	Under the Government of Tanzania's "Star Rating" accreditation initiative, each facility will have a quality improvement plan and efforts will be made to help such a facility achieve a higher Star Rating. Monitoring and supervision of due diligence measures related to environmental and social issues will be a part of World Bank

Risk Description	Risk Management
	supervision. The program will include a process of ongoing consultations, and a capacity building and training program to ensure the implementation of measures meet the needs of the beneficiaries. The details about the implementation will be included in the Program Operations Manual. The Program's annual capacity building plans are expected to help to address this issue.
Criteria #2: Contextual Risk Factors	
Exclusion in consultations, monitoring and feedback. The likelihood that some groups of people including those in hard-to-reach areas may be excluded from the planned social accountability mechanisms aimed at improving health care services exists.	Overall the SAc indicators score indicates very little is being done to provide for the 'demand side' of decision making and management of health services. In addition, the lower level health facility governing and Council Health Committees are not fully functional. The Program will therefore require a strengthened and incentivized SAc system which demands community engagement plans as part of the Comprehensive Council Health plans[4].
Criteria #3: Institutional capacity & complexity risks	
Weak Participatory Planning, Monitoring and Decision Making: Participatory decision making based on inclusive planning is no longer the norm. Communities appear to have no information on the services delivered and have limited opportunities to engage or provide feedback on health service delivery. A formalized and effective complaint redress mechanism to address social and environmental issues do not function as in the past years.	Program will strengthen the existing systems that allow the community and other stakeholders to be represented in the Village Social Welfare Committee and health facility governing committees to be fully constituted and functional. This is provided for under the assessment of performance for health facilities and that for LGAs. The committees will work towards public information dissemination.
Staffing and skills mix in the Program is insufficient to handle environmental and social management issues	The Program will assess capacity needs of staff for environmental and social management and ensure that all necessary staffing is available with adequate skills. The Program will appoint focal points for Environmental and Social management for monitoring and implementation of the ESSA. The Program will be incentivized to provide adequate resources to environmental and social management. Training on costing, implementation and monitoring of Environmental and Social actions and Grievance Redress mechanisms will be included in the capacity building program.
Annual Performance Audit does not include the requirement or the technical expertise to assess performance of the ESSA	Terms of Reference for consultants will ensure that individuals with adequate skills are hired to assess environmental and social management systems along with social audits/social accountability and implementation of ESSA

[4] Stakeholder engagement plans to be developed, financed, and implemented that will ensure VMGs are consulted

Risk Description	Risk Management
Critera#4: Reputational & Political risks.	
Delayed Implementation of decisions. Due to financial and other constraints, key decisions may take long to come to fruition. This can discourage those responsible for key improvements in service delivery.	Champion identification, buy in and consensus building among key stakeholders is critical. In addition, information dissemination and awareness raising activities for environmental and social due diligence measures will be built into the Program.

SECTION V: ASSESSMENT OF ENVIRONMENTAL AND SOCIAL MANAGEMENT SYSTEMS RELEVANT TO IIP

5.1 National Policy and Legislative Framework

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

5.1.1 Environment Management

The National Environmental Policy (2021)

The National Environmental Policy (NEP) provides the framework for incorporating and mainstreaming environmental and social considerations into decision-making in Tanzania. The original NEP was issued in 1997 and led to notable achievements in environmental management, including the enactment in 2004 of its main implementing legislation, the Environmental Management Act (EMA). However, the Government realized that, despite the positive results of implementing the 1997 policy, there are still significant limitations that constrained effective implementation. These concerns include: inadequate coordination among sectors in managing environmental issues; low public awareness and knowledge on environmental management; inadequate land use planning at various administrative levels; inadequate enforcement and compliance with legislations related to environmental management; inadequate alternative sources of energy and dependence on charcoal and firewood as the main source of energy; increased encroachment of water sources; limited capacity in terms of human and financial resources, infrastructure, technology, and tools; and inadequate environmental research, data and information on environmental issues. Furthermore, new environmental challenges that were not explicitly addressed in the 1997 policy have emerged. These include: climate change; invasive species; electrical and electronic equipment wastes (e-wastes); genetically modified organisms; management of oil and gas; and sound management of chemicals. For these reasons, NEP has been revised.

The specific objectives of NEP 2021 are:

- To strengthen coordination of environmental management in sectors at all levels;
- To enhance environmentally sound management of land resource for socioeconomic development;
- To promote environmental management of water sources;
- To strengthen conservation of wildlife habitats and biodiversity;
- To enhance conservation of forest ecosystems for sustainable provision of environmental goods and services;
- To manage pollution for safe and healthy environment;
- To strengthen the national capacity for addressing the impact of climate change;
- To enhance conservation of aquatic systems;

- To ensure safety in application of modern biotechnology;
- To promote gender considerations in environmental management;
- To promote good governance in environmental management at all levels; and
- To ensure predictable, accessible, adequate and sustainable financial resources for environmental management.

EMA continues to be the principal implementing law for NEP, and the ministry responsible for the environment continues to have the role of coordinating policy implementation. NEP defines the responsibilities of other relevant actors including line ministries, NEMC, regional and local governments, development partners, and NGOs.

National Policy Guidelines for Health Care Waste Management in Tanzania (2017). The policy recognizes that healthcare service provision is associated with healthcare waste generation; and that healthcare wastes have a greater potential to cause infection and injury than any other type of waste. The policy add that inadequate and inappropriate HCWM may result into serious consequences on public health and the environment. Thus, the policy calls for proper management of HCW to prevention infections among health workers and patients, to enhance public health and to protect environment. The broad policy objective is to provide technical guidance on safe healthcare waste management and to ensure compliance with HCWM regulations, standards, procedures and specifications in order to protect public health and safeguard the environment. The policy also provides for HCW classification and guidelines: for HCW Minimization, Re use-and Recycling; Segregation of HCW; collection and onsite-transportation of HCW; storage of HCW; offsite transportation; HCW treatment; disposal methods; Water, sanitation and Hygiene; Waste Water Management; Landscaping, Gardening and Outdoor Spaces. The policy also stipulates the roles of different stakeholders in HCW management.

The policy directs every health care facility to be responsible in handling the HCW it generates. Health facilities are required to minimize, segregate, collect, store, label, transport, treat and dispose all HCW in the manner prescribed in the policy and other laws and regulations regarding HCWM so as to safeguard public health and the environment. Healthcare facilities located within the same vicinity are also encouraged to share treatment and disposal equipment in order to minimize public health risks and the environment. The policy also requires MoH to collaborate with the Vice President Office –Division of Environment, PO-RALG and other stakeholders in promoting centralized biomedical waste treatment facilities, ensuring effective management of HCW, developing Information, Education and Communication strategies with which to educate the public on the importance of proper HCW management and the role of the community. In addition, the policy mandates and requires the ministry to facilitate and collaborate with other stakeholders in conducting M&E and operational research on priority areas for HCW management.

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

Management of Health Care Waste (HCW).
The management of HCW in Tanzania are stipulated in the following legislations:

Environmental Management Act (EMA, 2004). Section 137 of the EMA (2004) states that the Minister shall, in collaboration with the Minister responsible for health, ensure that healthcare wastes are sorted and stored in prescribed coded containers and transported for disposal in healthcare wastes refuse trucks designed and registered for that purpose. The act direct, the Minister of the Environment to collaborate with the Minister responsible for Health, in prescribing the best possible method for final disposal of various types of healthcare wastes.

The EMA (2004) defines healthcare wastes to include but not limited to the infectious wastes, pathological wastes, sharp wastes, pharmaceuticals, genotoxic, radioactive wastes, coagulated blood wastes and drugs. EMA has established environmental units in all ministries and environmental committees at the regional, district and village levels. Within each ministry, it is the Environmental Section's responsibility to ensure that environmental concerns are integrated into the ministry's development plan and project implementation in a way that protects the environment.

Public Health Act (2009)
Section 92 of the Act comprises provisions on handling and disposal of healthcare waste and other wastes. The Act states that the Authority (District or Urban Authority) shall, in collaboration with the Ministers responsible for Health, Environmental Management and Local Government Authorities - (a), ensure that healthcare wastes are sorted and stored in prescribed coded containers and transported in waste trucks designed and registered for that purpose, (b) prescribe the best possible methods for final disposal of various types of healthcare wastes.

The National Strategic Plan for Health Care Waste Management (2018 -2022). The strategy is envisaged to provide quality HCW management services for the prevention and control of diseases through the use of environmentally friendly technologies, strengthening of institutional capacity, Operational Research, mobilization of resources, promotion of Public Private Partnership and community engagement at various levels of implementation.

Generic Waste Management Guidelines (2015): Although these Guidelines have not yet been formerly approved, Section 87 states that "healthcare waste" includes the infectious wastes, pathological wastes, sharps, pharmaceuticals, gene toxics, radioactive wastes, coagulated blood wastes and drugs. Section 89 states that healthcare wastes shall be managed in accordance with the guidelines and standards under the Environmental Management Act.

Hazardous Wastes (Control and Management) Regulations (2019)
Part VII - Sections 45 -51 deal with the Segregation of health care waste, Securing and packaging of health care waste, Treatment of health care waste, Storage of health care waste, Transportation of health care waste, Transfer stations and Monitoring.

The Environmental Impact Assessment and Audit Regulations of 2005 and its amendment of 2018

The Environmental Impact Assessment and Audit Regulations No.349 of 2005 were made pursuant to Section 82 (1) and 230 (h) and (q) of the Environmental Management Act Cap 191 of 2004 and its amendment in 2018. The regulations stipulate the procedures and requirements for undertaking ESlA in various types of development projects with significant environmental impacts. In addition, the Regulations provide a list of projects that qualify for Environmental Assessment procedures in Tanzania. Regulation

46(1) classifies projects into two types: (i) Type A Projects requiring a mandatory ESlA; and (ii) Type B projects requiring a Preliminary Environmental Assessment (PEA). The First Schedule lists typical examples of Type A and B projects. The Regulation was amended in 2018 by **The Environmental Management (Environmental Impact Assessment and Audit) (Amendment) Regulations, 2018,** in which project categorization was changed to "A" category for Mandatory Projects, "B1" category for Borderline Projects, "B2" category for Non-Mandatory, and "Special Category. ESIA is mandatory for Category "A" projects and may or may not be required for Category B1 depending on NEMC's findings when it reviews the Project Brief and Scoping Report that include a proposed ESMP. Processing times for EIA Certificate applications were shortened by in the amendment. The amendment also allows the Minister to issue a Provisional Environmental Clearance on advice from NEMC for industrial or agro-processing projects and projects determined by the Minister to be in the national or public interest. The recipient of a Provisional Environmental Clearance is obligated to submit the project ESIA within four months and to comply with other conditions that may be in the clearance.

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

Energy and Water Utilities Regulatory Authority (EWURA), 2001: The general functions of EWURA are to regulate the provision of water supply and sanitation services by a water authority or other person including the establishment of standards related to equipment and tariffs chargeable for the provision of water supply and sanitation services. Thus EWURA is amongst key players with respect to the proposed project.

Water Supply and Sanitation Act No 12 (2009): The Act provides a legal framework for water supply and sanitation. It outlines the responsibilities of the government authorities involved in the water sector and establishes Water Supply and Sanitation Authorities as commercial entities. The National Water Sector Development Strategy 2006-2015 sets out a strategy for implementing the National Water Policy, which aims to achieve sustainable development in the sector through "efficient use of water resources and efforts to increase the availability of water and sanitation services." The National Water Sector Development Program of 2006-2025 sets out to promote the integration of water supply and sanitation with hygiene education.

Environmental Management (Air Quality Standards) Regulations, 2007: The object of these Regulations shall be to-.

- Set baseline parameters on air quality and emissions based on a number of practical considerations and acceptable limits;
- Enforce minimum air quality standards prescribed by the National Environmental Standards Committee;
- Help developers such as industrialists to keep abreast with environmentally friendly technologies; and
- Ensure protection of human health and the environment from various sources of pollution.

Environmental Management (Water Quality Standards) Regulations, 2007: The object of these Regulations is to-

- Protect human health and conservation of the environment;

- Enforce minimum water quality standards prescribed by the National Environmental Standards Committee;
- Enable the National Environmental Standards Committee to determine water usages for the purpose of establishing 7 environmental quality standards and values for each usage; and
- Ensure all discharges of pollutants take account the ability of the receiving waters to accommodate contaminants without detriment to the uses specified for the waters concerned.

Environmental Management (Solid Waste and Management) Regulations, 2009: this is a provision for management of solid wastes from various sources e.g. hospitals. It provides for institutional mandates with respect to various types of wastes including hospital wastes. It prohibits disposal of certain solid wastes including hospital wastes into receptacles.

Hazardous Waste Regulations (2019): The Part VII of this act is concerned with healthcare waste and specifically on: Segregation of health care wastes; Securing and packaging of healthcare waste; Treatment of healthcare waste; Storage of healthcare waste; Transportation of healthcare waste; Transfer stations; and Monitoring.

Institutions Arrangement for management of HCW

According to the aforementioned laws and guidelines, in Tanzania the institutions responsible for dealing with management of Hazardous wastes, specifically Hospital Wastes are: Ministry of Health (MoH), the National Environment Management Council (NEMC); Local Government Authorities (LGAs); and Hospitals and Health Canters. EMA 2004 stipulates institutional arrangement for the overall management of the environment and provides mandates to various institutions. However, the Act does not link management of healthcare waste with the responsible institutions directly. Of all the instruments in place, there has not been one for disposal. According to the Act, there have to be Regulations for disposal of Hazardous healthcare wastes.

5.1.2 Legal Framework for Social Protection

Constitution of Tanzania 1977 (amended in 1998, 2005)

Article 9. That human dignity and other human rights are respected and cherished; that human dignity is preserved and upheld in accordance with the spirit of the Universal Declaration of Human Rights; that the Government and all its agencies provide equal opportunities to all citizens, men and women alike without regard to their color, tribe, religion, or station in life;

Article 13. *(4)* No person shall be discriminated against by any person or any authority acting under any law or in the discharge of the functions or business of any state office.

Article 14. Every person has the right to live and to the protection of his life by the society in accordance with law.

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

While Tanzania's Constitution stipulates which laws apply across the entire United Republic, labor laws are not included. Therefore, mainland Tanzania and Zanzibar have separate legislations governing child labor. Each has a different minimum age for work and laws governing hazardous labor. Zanzibar has two different minimum wages for work. Article 100 of the Zanzibar Children's Act of 2011 prohibits children

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

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

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

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

All urban land falls under General Land Category, except land which is covered by laws defining reserved land, or that which is considered hazardous. General land is governed by the Land Act. Reserved land includes environmental protected areas as well as areas intended and set aside for spatial planning and (future) infrastructure development. Rights of occupancy are given in two categories, which separate the rights of citizens and non-citizens to occupy land. Section 19 (1) confers right to all citizens to occupy land; 19 (2) and 20(1) excludes non-citizen to occupy land except for the purpose of investment (Tanzania Investment Act 1997). Property rights can be created over surveyed general land or reserved land; for a period of 33, 66 or 99 years; confirmed by a Certificate of Title.

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

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

The Occupational Health and Safety (First aid and Welfare Facilities) Rules, 2015: These occupational health and safety (first aid and welfare facilities) rules provide for the duty and responsibilities of the employer, first aider and employees, regarding first aid and welfare facilities. The law has provisions and directives on first aid and supply of basic facilities such as: first aid attendant qualifications; basic requirements related to equipment, supplies, facilities, first aid attendants and services; first aid procedures and information on post exposure; sanitation, accommodation for clothing, change-rooms and dining room; prohibition, seats, and condition of rooms and facilities; first aid attendant, first aid records, first aid attendant responsibilities; and offences and penalties.

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

- ensure that healthcare wastes are sorted and stored in prescribed coded containers and transported in waste trucks designed and registered for that purpose;
- prescribe the best possible methods for final disposal of various types of healthcare wastes;

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

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

5.2 Institutional Capacity

This Section presents the institutional framework for management of environmental and social systems as relevant to the project. On the overall, management responsibilities for these systems rest upon different functionaries located in a semi-hierarchical structure but which have considerable decentralized mandates and responsibilities, from the national level to the grassroots at the Mtaa and Village levels. These responsibilities are provided by the Environmental Management Act (EMA) (2004), which also guides the implementation of environmental management activities in Tanzania. The structure is depicted in Figure 2.

5.2.1 Institutional Responsibilities for Environmental and Social Protection

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

The **Ministry of Health** is responsible for the overall stewardship of the health sector matters. The Ministry of Health is responsible for policy development, strategic planning, resource mobilization and monitoring and evaluation in the health sector. The Ministry issues standardized guidelines for monitoring quality control of works including aspects related to location and setting of health facility buildings and their ancillary facilities.

As per the policy of Decentralization by Devolution, MoH does not have direct responsibility for operational service delivery at the LGA level. However, it provides guidance to service providers and monitors the quality of the service delivery. The Tanzania Quality Assurance Framework, with an accreditation system (Star rating for health facilities), will be an important new tool for the Ministry in

guiding the health sector. In this system, incentives (rewards and penalties) are expected to be instituted with regular monitoring and feedback to provide for remedial actions.

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

Specialized hospitals that function under the responsibility of MoH are expected to become referral hospitals. Training institutions (116, including private institutes) for pre-service training of paramedical staff are also directly under the Ministry. Eight Zonal Resources Centers under MoH offer continuing professional development and support to training institutions.

Decentralization in the health sector has not fully materialized, something which hinders the operations of the facilities. Health facilities have limited financial autonomy to utilize their own funds and most PHC facilities do not even have a bank account.

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

The Ministry of Community Development, Gender, Elderly and Children (MCDGEC) is a newly-established ministry responsible for overseeing and coordinating the implementation of five policies and two laws which foster social protection and addressing vulnerability issues. The policies and laws are: Community Development Policy (1996); Women and Gender Development Policy (2000); National Non-Governmental Organization Policy (2001); National Aging Policy (2003) and Child Development Policy (2008). While Laws include Non-Governmental Organization Act No.24 (2002) and Law of the Child Act No.21 (2009). Together, these policies provide strategies for gender equity in all aspects of social, political, and economic life; gender equity in decision-making; girl children's right to education; protection of minors against sexual abuse and other forms of violence; and establishment of anti-VAWC platforms at community level.

According to Government Notice No. 144 of 22nd April, 2016 the MCDGEC is mandated for: (i) Policies on Community Development, Gender, Elderly and Children and their implementation; (ii) Coordination of NGOs dealing with the functions under this Sector; (iii) Facilitate collaboration with International Organizations mainly: UNICEF and UN-WOMEN; (iv) Performance improvement and Development of Human Resources under this Ministry; as well as (v) working in collaboration with Extra - Ministerial Departments, Parastatal Organizations, Agencies, Programs and Projects under this Ministry. In summary the ministry has been entrusted to coordinate gender-related work in Tanzania.

In preventing ***Gender Based Violence and Sexual Exploitation and Abuse*** the MCDGEC works closely with different bodies at the national, regional and local levels. These includes:

a) The Prime Minister's Office (PMO); The President's Office - Regional Administration and Local Government (PO-RALG); The Ministry of Home Affairs (MoHA - Police, Prison and Immigration - Human trafficking); The Ministry of Constitution and Legal Affairs

(MoCLA); Registration, Insolvency, and Trusteeship Agency (RITA); The Ministry of Education, Science and Technology (MoEST); Tanzania Social Action Fund (TASAF); Commission for Human Rights and Good Governance (CHRAGG); The Ministry of Agriculture, Livestock Development and Fisheries (MoALF), Ministry of Industry, Trade and Investment (MoITI), the Ministry of Energy(MoE), The Ministry of Finance and Planning (MoFP-Commissioner of Budget); Tanzania Commission for AIDS (TACAIDS); Tanzania Food and Nutrition Centre (TFNC), National Bureau of Statistics (NBS), and representatives of development partners.

b) At the Local level, (inclusive of regions, districts, wards, and villages), there is also a National Plan of Action to End Violence against Women and Children in Tanzania 2017/8-2021/2 (NPA-VAWC 2017/18 – 2021/22). The NPA-VAWC Protection Committees have been established at National, Regional, District, Wards and Village levels to lead operationalization of NPA – VAWC.

The President's Office Regional Administration and Local Government (PO-RALG) is the central office for government coordination, and also manages the Regional Administration and Local Government**.** PO-RALG, through the Local Government Authorities (LGAs), is responsible for coordination directives to the regions and districts to ensure effective implementation of health initiatives at LGA levels. The Health Department in PO-RALG oversees the overall coordination and administration of Regional Health Management Teams (RHMTs) / CHMTs with regard to health commodities activities. The RAS/ RHMT is responsible for monitoring and implementation coordination of health initiatives at LGA level.

Local Government authorities (LGA) at the Council level (City, Municipal, Town and District councils) are obliged by section 36 (1), (2) of EMA (2004) to designate an Environmental Management Officer (EMO) and to form Environmental Management Committees. EMA 2004 delineates the roles and functions of officers and committees for environment management at the level of local government administration. LGAs are to appoint an environment management officer to oversee the day-to-day management of environmental aspects in collaboration with city, municipal or district environment management committees. The functions of the EMO are to:

- Advice the environmental management committee to which he/she belongs on all matters related to the environment.
- Promote environmental awareness in the area he/she belongs on the protection of the environment and the conservation of natural resources

LGAs maintain Environmental Management Committees the membership of which typically consists of:

- District planning officer, who coordinates the planning process;
- District natural resources officer, who manages the development of natural resources/forestry, wildlife, beekeeping, fisheries, and so forth;
- District agricultural and livestock development officer, responsible for land use and management;
- District water engineer;

- District health officer; and
- Co-opted members (depending on nature of project).

The Committees are supported by a designated or appointed Environmental Management Officer, employed by the District LGA but linked to and trained by NEMC, and having these main functions:

- Issuance of ESIA registration forms to developers and operators and provision of information on relevant policy, legal and other administrative requirements at the district level;
- Coordination of the ESIA/PESA process at the district level for Category C projects; and
- Linkage with NEMC on all undertakings within the district.

The **Office of the Vice President**: The vision of the Environmental Division of the VPO is "to attain sustainable human development, eradication of poverty, security and equitable use of resources on a sustainable basis to meet the basic needs of the present and future generations without degrading the environment or risking health or safety and also to maintain the union between the mainland Tanzania and Zanzibar". The mission of the VPO is "to formulate policies and strategies on poverty eradication, protection of environment and non-governmental organizations as well as co-ordinate all issues pertaining to the mainland Tanzania and Zanzibar". The VPO is responsible for overall policy guidance and advice on the development of strategic environmental vision, including formulation, analysis and appraisal of broad environmental policy as well as formulation and review of broad environmental goals, in conformity with such vision. The VPO provides a basis for a broad political legitimacy for the administration of strategic policy decisions on a routine and continuous basis for coordinated environmental management.

The Minister responsible for Environment in the Vice President's Office is responsible for matters related to the environment and shall in that respect be responsible for articulation of policy guidelines necessary for the promotion, protection and sustainable management of environment in Tanzania. The Minister also approves the EIA Certificates following recommendations from NEMC

The Prime Minister's Office manages the emergency preparedness and Tanzania Commission for AIDS (TACAIDS), with which the Health Emergency Preparedness Unit and COVID-19 coordination department in MoH work closely. PMO is also mandated to coordinate and strengthen efforts of all stakeholders involved in the fight against HIV and AIDS.

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

The **National Environment Management Council** (NEMC) is responsible for ensuring that development programs comply with all relevant social and environmental laws and regulations. It is responsible for enforcing pollution control and performing the technical arbitration role in the undertaking of EIAs. The sectoral and district environmental units are responsible for developing sectoral guidelines within the framework of the national guidelines, issuance of ESIA registration forms and provision relevant information on policies and other administrative requirements. NEMC exercises periodic monitoring to ensure no adverse cumulative impacts from school construction program at the

national level. It provides oversight and technical assistance to the Local Government Authorities when required.

To ensure effective monitoring and implementation of environmental and social safeguards in the country, NEMC operates under nine (9) Zonal Offices namely: (i) Northern Zone - Arusha, Kilimanjaro and Manyara regions; (ii) Lake Victoria Zone - Mwanza, Mara, Shinyanga, Geita and Simiyu; (iii) Central Zone - Dodoma, Singida and Tabora; (iv) Western Zone - Kigoma, Kagera and Rukwa; (v) Southern Highlands Zone - Mbeya, Iringa, Njombe and Songwe; (vi) Southern Zone - Ruvuma, Mtwara and Lindi; (vii) Eastern Zone (North) - Tanga, Bagamoyo, Chalinze; (viii) Eastern Zone (South) - Kigamboni, Temeke and Ilala; and (ix) Morogoro and Rufiji Special Zone. The RMNCAH -N program will benefit from this decentralized capacity.

Institutional Gaps: Although the NEMC officers at the head office and zonal offices are well qualified and possess the requisite skills necessary for ensuring that environmental assessments (i.e. ESIA, Audit) are compliant with regulatory requirements, inadequate staffing and funding limit the agency's capacity to supervise all on-going projects scattered over a large geographical area and enforce compliance with license obligations and regulations through on-site monitoring. NEMC officers, therefore, focus mostly on the review and monitoring of high-risk projects at the expense of other projects. In the end, monitoring is often left for self-monitoring by the proponent of the project, with little oversight from NEMC independent view particularly at LGAs and other lower levels.

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

The enforcement of occupational health and safety standards is accomplished through: workplace registration, undertaking statutory inspections (electrical inspection, pressure vessels inspection and lifting equipment inspection); risk assessment; training and information on occupational health and safety, scrutiny and approval of workplace drawings/ plans. Other activities include; diagnosis of occupational diseases; occupational health surveillance, work environment monitoring, investigation of accidents; authorization of private OHS Providers.

Institutional Capacity: OSHA has three main directorates each headed by director: The Director of Training, Research and Statistics; The Director of Technical Support (Health and Safety); and the Director of Business Support Services. OSHA is represented in six (6) zones across the country which are Coastal Zone, Northern Zone, Lake Zone, Central zone, Southern highlands zone and Southern zone. The officers in these zones are qualified and possess the requisite skills necessary for managing health and safety risks. However, the offices are understaffed, with the capacity assessment findings revealing that most officers are not able to cover their regions within the zones as required. The officers are also not given enough resources (including budget) to cover the regions assigned. This has made it difficult for the staff to enforce and monitor the health and safety requirements as per OSHA and WB's requirements, especially for infrastructure projects. Due to capacity problems, monitoring and enforcement by OSHA are mostly missing in many projects, with many active construction sites not being registered or visited by an officer as required by the national framework for safety.

In fulfillment of its responsibility of identifying hazards at workplaces and assessment of risks with a view of preventing accidents, diseases and damage to property, the Authority will play a key role in the program by inspecting and auditing of workplaces to promote best practices and ensure compliance with safety and health standards as set out in Occupational Health and Safety Act, 2003 and its subsidiary legislations.

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

There are a few other ministries important for elements of the health programs, e.g. **Agriculture and Food** with respect to nutrition, **Water and Energy** with respect to sanitation and water borne diseases, **Industries and Trade** with respect to international trade agreements, **Gender Women and Children** with respect to gender issues and maternal and child health, **Justice and Constitutional Affairs** with respect to health legislation. The Ministry of Health works closely with all these ministries to achieve the strategic objectives of HSSP III.

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

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

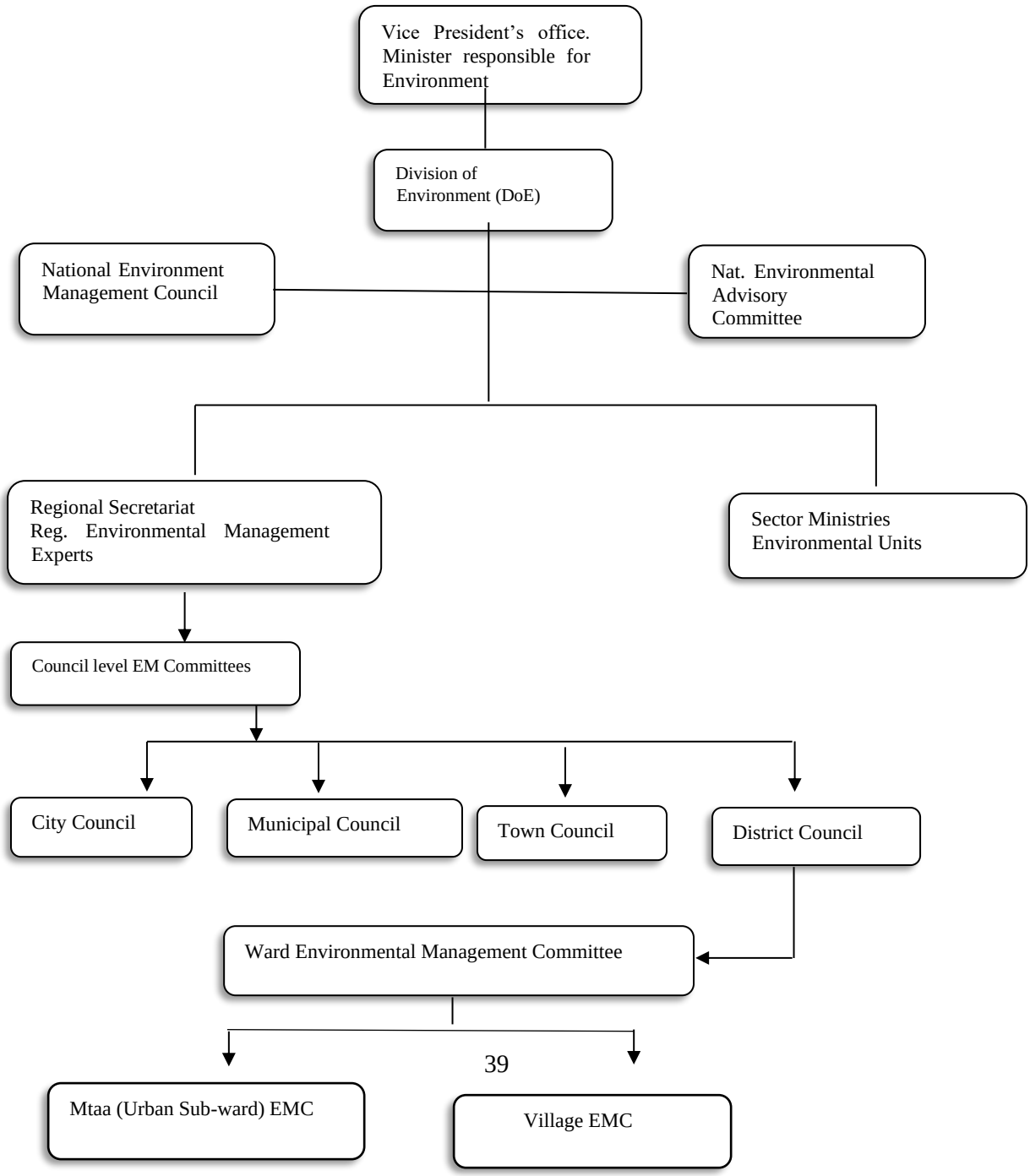
All ***Local Councils*** produce an annual Comprehensive Council Health Plan (CCHP), which incorporates all activities of the District Health Services, and all sources of funding at the council level (government funds, locally generated funds, local donor funds, etc.). The CCHP is produced by the CHMT,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

Implementation of health-related activities at primary healthcare facilities (Dispensaries, Health Centres and District Hospitals) is a responsibility of the Local Government Authorities. ***Council Health Management Teams (CHMTs)*** are the lowest local government level organs responsible for on-the-ground implementation of initiatives for primary healthcare facilities at district level. At community level,

representation to Hospital, Health Centre and Dispensary Management teams is provided for. In addition, a village health committee is the lowest village government structure responsible for health-related matters. Community representation in these lower level committees is increasingly being acknowledged and encouraged to apply social accountability mechanisms and tools like the community score cards (CSC), which assesses, plans, monitors and evaluates the delivery of health services. The CSC methodology brings together service users and providers of a particular service to jointly analyze issues in a particular service area and find a common and shared way to address them.

In summary, the institutional setup for environmental management and of which RMNCAH –N's Program will adhere is described in the Figure 2 below.

Figure 2: Institutional Set Up for Environmental Management in Tanzania Mainland



5.2.2 Process of Environmental Impact Assessment

The national EIA procedure requires the following steps:

- Registration – by proponents to NEMC for assessment
- Screening by NEMC - for making decisions on further environmental and social considerations (the process is outlined in Fig 2 below)
- Scoping by proponent- for identification of key issues to guide an ESIA
- ESIA – which will also include an environmental and social management plan
- Review – by the Technical Review Committee (TRC) comprised of all project relevant technical persons. If needed, the TRC process may require a public hearing process
- Environmental decision-making which entails permissions (or refusals if need be) for development of the project.
- Project Implementation
- Environmental audits: - for monitoring and auditing for verification of compliance, impacts, and feedback
- Decommissioning: end of project life – the report which is submitted to NEMC

5.2.3 **Responsibilities during Registration and Screenin**g

In the screening process, the Regulatory Authorities (NEMC, the District, Municipal or Town authorities) that is the mandated to oversee the implementation and execution of EIA is responsible for the following:

- Issuing registration forms for the proposed project
- Availing technical advice on procedural requirements, policies and regulations.
- Screening all proposed projects (public or privately owned)
- Preparing and issuing screening reports to the developer

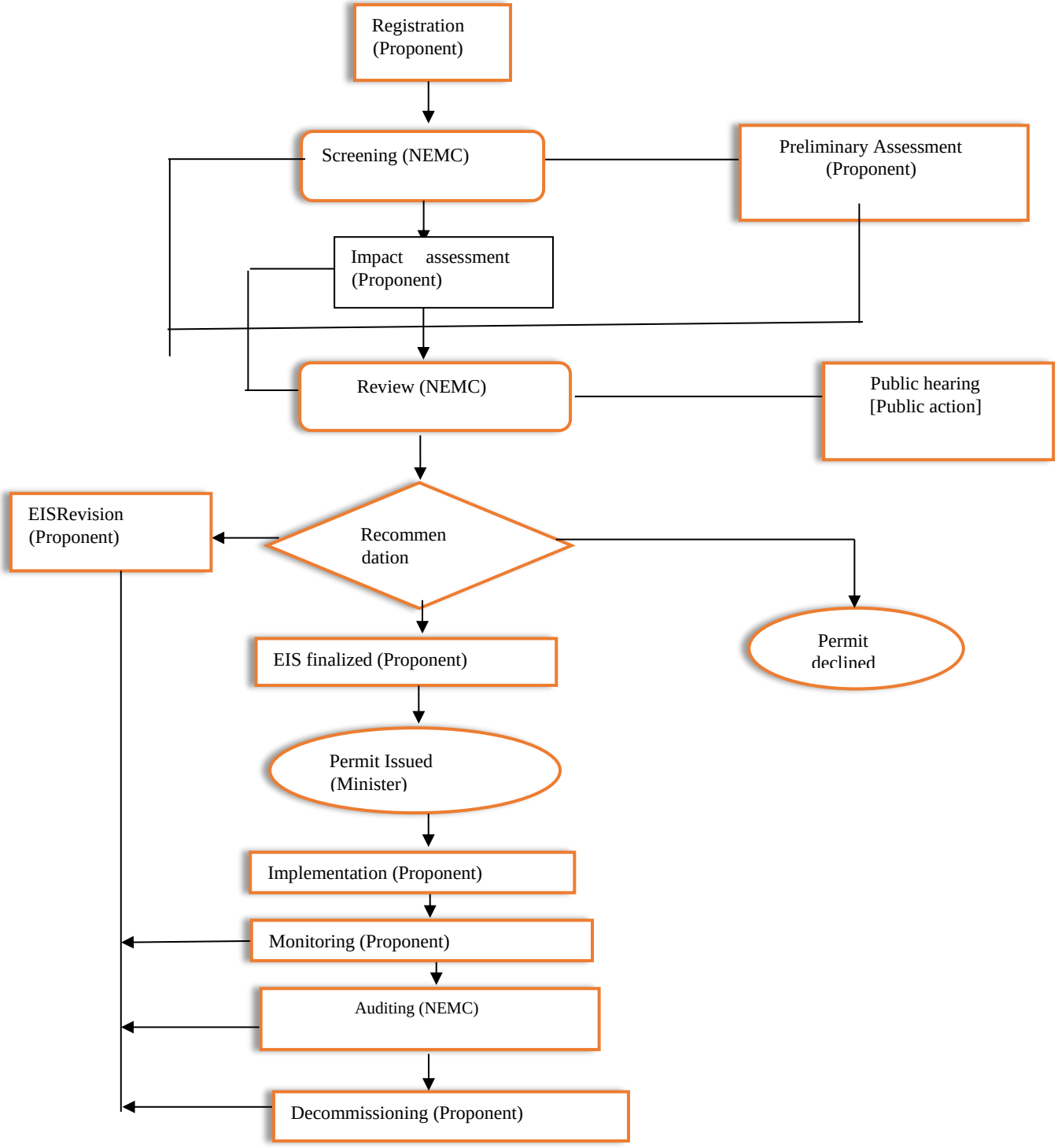
Compliance and reporting is an obligation for to the project proponent in terms of securing and filling in the Registration forms accordingly and timely; availing all relevant information about the proposed project as requested by the regulatory authority according to section 87 (3 &4) of EMA 2004, and subscribing to all fees associated with EIA process.

5.3 Overall Project Compliance and Reporting

The stages and institutional responsibilities for the screening, preparation, assessment, approval and implementation project activities as illustrated below in Figure 3 depict the overall relevant compliance and reporting processes for environmental assessment and screening.

NEMC and the Minister for Environment remain with the overall institutional responsibility for checking environmental and social risks and required permits.

Figure 3*:* Environmental Assessment Process in Tanzania



5.4 Summary of System Assessment Matrix

The summary of system assessment is presented in Table 7 below:

Table 7: Matrix of System Assessment

(Core Principle applicability findings, strength and weaknesses)

Core Principle 1: General Principle of Environmental and Social Management*:* Environmental and social management procedures and processes are designed to (a) promote environmental and social sustainability in Program design; (b) avoid, minimize or mitigate against adverse impacts; and (c) promote informed decision-making relating to a program's environmental and social effects.	
Key Planning Elements*:* PforR Program Systems will: • Operate within an adequate legal and regulatory framework to guide environmental and social impact assessments at the program level. • Incorporate recognized elements of good practice in environmental and social assessment, including (a) early screening of potential effects; (b) consideration of strategic, technical, and site alternatives (including the "no action" alternative); (c) explicit assessment of potential induced, cumulative, and trans-boundary impacts; (d) identification of measures to mitigate adverse environmental or social impacts that cannot be otherwise avoided or minimized; (e) clear articulation of institutional responsibilities and resources to support implementation of plans; and (f) responsiveness and accountability through stakeholder consultation, timely dissemination of program information, and responsive grievance redress measures.	
The Core Principle No. 1 Is considered Applicable Core Principle 1 is considered in terms of environmental and social management (ESM) for the health sector, as a key component of good service delivery (i.e. measures included under the Program's system strengthening measures for enhanced accountability and oversight mechanisms).	
Summary Findings There is an adequate national regulatory framework in Tanzania and technical guidelines exist for environmental and social due diligence with respect to the potential impacts of the programme. There are also environmental and social procedures under the ongoing World Bank-funded health programmes, which have been deemed satisfactory. However, implementation has not been up to the expected standards and the assessed weaknesses are systemic, related to insufficient resources – both financial and manpower - for overseeing and monitoring of implementation of environmental and social measures, timely procurement of consumables, weak coordination and inadequate attention to environmental concerns. Additionally, there is a need to strengthen and update some of the technical guidelines for asbestos management, incinerator usage and management, and environmental enhancements related to sanitation and water.	
System Strengths	**Gaps**

EMA, the Environmental Assessment and Audit Regulations, and the procedures established by NEMC provide the basis for full achievement of objectives defined for this core principle. NEMC has strengthened its capacity by posting additional personnel in its nine zonal offices and has refined its risk categories, screening procedures, and ESIA/ESMP preparation processes in a 2018 revision to the Environmental Assessment and Audit regulations. There are also health sector policies, laws, and strategies and guidelines dedicated to manage HCW: National Policy Guidelines for Health Care Waste Management in Tanzania (2017); The Public Health Act was enacted in 2009; and the National Strategic Plan for Health Care Waste Management (2018 -2022). In MoH and PO-RALG, there is recognition of environmental sustainability and the desire for Program interventions. There is willingness to address issues that are compromising efficiency and effectiveness of the application of environmental and social management processes in the sector. Direct larger environmental (related to construction) and social impacts in the health sector can and have been adequately managed. Satisfactory acceptance of the implementation of environmental and social practices in ongoing health programs in Tanzania. Measures to mitigate impacts had reasonable success in their implemented.	**Weak implementation** - Although the direct impacts and risks are generally modest, environmental management activities are weak in some areas, for instance systematic inspection, monitoring and enforcement[5]. The Healthcare Waste Management Program is severely ***under-resourced (manpower and funds)*** which prevents it from providing satisfactory oversight. There also could be *limited awareness* of environmental health risks associated with poor quality of water, *inadequate sanitation and hygiene*, which prevents adequate attention be paid to these issues. Poorly run incinerators, slow-burning pits where unsegregated waste is burnt are commonplace among health facilities. The practice can have significant effects on the health and wellbeing of communities, leading to unacceptable health and performance indicators. Thus, they need to be managed with increased operational training and regular maintenance. ***Storage of medication*** without appropriate power back-up can render them ineffective or expired. Participatory Planning, implementation and monitoring of development activities including those that are health related appears very weak. There is limited information on performance of PHC facilities with regard to resolution of challenges using the participatory mechanisms. Unstable internet connectivity services and low connectivity and overall limited access to information by the communities makes it difficult for them to participate meaningfully Weak health facility committees and in some cases their inexistence affect progress in the achievement of inclusive consultations, feedback and decision-making outcomes. **Weak grievance handling mechanisms in the facilities**

[5] This is primarily due to (i) weak and insufficient institutional and technical capacity; (ii) inadequate resources, including manpower, technology and equipment; (iii) inadequate training, monitoring and enforcement; and (iv) weak inter-institutional and coordination between the various related agencies.

Plans are in place to ensure participatory environmental and social assessment process for program sustainability. There are Healthcare Waste Management Plans, and other technical guidelines and standards on medical waste management and monitoring. Guidelines for the establishment of committees at health facility and village level for purposes of inclusive consultations and are made available to the stakeholders. Guidelines and training programmes for social accountability mechanisms (that include grievance mechanisms) exist.	
Technical Guidance and Implementation Capacity: There are technical guidelines and standard designs for PHC centers that are presently being used/or newly prepared by the MoHCDGEC. There is an opportunity to strengthen implementation capacity for monitoring, evaluation and reporting, along with public participation and disclosure. Additionally, systemic changes to promote sustainable and "greener" building designs will allow better resource management. Strengthening cooperation and inter-sectoral coordination around the environmental issues and use of Environmental and Social Management Frameworks/Plans would improve their implementation.	***Technical guidelines*** need updating to include emerging issues such as (i) greener solutions in new buildings, (ii) ways of retrofitting old buildings with recycling and energy efficient measures. New guidelines on climate adaptation and resilience measures will have to be developed.

***Core Principle 2: Natural Habitats and Physical Cultural Resources**:* Environmental and social management procedures and processes are designed to avoid, minimize and mitigate against adverse effects on natural habitats and physical cultural resources resulting from program.

***Key Planning Elements**:* PforR Program Systems will:

- Includes appropriate measures for early identification and screening of potentially important biodiversity and cultural resource areas.
- Supports and promotes the conservation, maintenance, and rehabilitation of natural habitats; avoids the significant conversion or degradation of critical natural habitats, and if avoiding the significant conversion of natural habitats is not technically feasible, includes measures to mitigate or offset impacts or program activities.
- Takes into account potential adverse effects on physical cultural property and, as warranted, provides adequate measures to avoid, minimize, or mitigate such effects.

The Core Principle No. 2 is Not Applicable

The provisions in Core Principle 2 are considered as part of the ESIA process analyzed under Core Principle 1. The analysis confirmed that Program investments will neither impact nor convert critical natural habitats as all the proposed investments are brown investments and will not cause degradation of biodiversity. New PHC centers will not be constructed and rehabilitation will be undertaken in the existing facilities within program-funded sites and all construction will be done in urban areas consistent with the existing urban planning.

System Strengths	**Gaps**
The Tanzanian ESIA process considers physical cultural resources, including screening for archaeological, historical and cultural sites. The assessment shows that impacts on cultural sites are taken into account in program design and implementation and appropriate mitigation measures adopted. Aside from the provisions of the EMA, ***National Environmental Action Plan*** (2013), Forest Policy 2007, Wildlife Policy 2007, among other relevant regulatory activities, GoT is revising the National Biodiversity Strategy and Action Plan of 2001 to meet the UN Aichi Biodiversity Targets agreed in 2010, which will set the parameters for conservation and natural habitats – aquatic, terrestrial and agri-biodiversity. This has also been strengthened by the establishment of a national coordinating body that will oversee all aspects, from environmental safeguards to information dissemination.	There are no significant inconsistencies between Bank Policy - Program-for-Results Financing and Tanzania's policies, laws, and regulations related to natural habitats.
Actions and Opportunities	**Risks**
The opportunities and actions identified for strengthening the system for Core Principle 1 are applicable to Core Principle 2.	The risks/mitigation actions identified for strengthening the system for Core Principle 1 are applicable to Core Principle 2.

Core Principle 3: Public and Worker Safety: Environmental and social management procedures and processes are designed to protect public and worker safety against the potential risks associated with (a) construction and/or operations of facilities or other operational practices developed or promoted under the program; (b) exposure to toxic chemicals, hazardous wastes, and otherwise dangerous materials; and (c) reconstruction or rehabilitation of infrastructures located in areas prone to natural hazards.

Key Planning Elements*:* PforR Program Systems will:

- Promotes community, individual, and worker safety through the safe design, construction, operation, and maintenance of physical infrastructure, or in carrying out activities that may be dependent on such infrastructure with safety measures, inspections, or remedial works incorporated as needed.
- Promotes the use of recognized good practice in the production, management, storage, transport, and disposal of hazardous materials generated during programme construction activities or operations; promotes the use of integrated pest management practices to manage or reduce pests or disease vectors; and provides training for workers involved in the production, procurement, storage, transport, use, and disposal of hazardous chemicals in accordance with international guidelines and conventions.
- Includes measures to avoid, minimize, or mitigate community, individual, and worker risks where program activities are located within areas prone to natural hazards such as floods, hurricanes, earthquakes, or other severe weather or climate events.

The Core Principle No. 3 is Considered Applicable

The provisions in Core Principle 3 are considered as part of the ESIA process analyzed under Core Principle 1. Complementing that analysis, the review found that Core Principle 3 is applicable to the Program as there is physical infrastructure being financed and issues related to medical wastes.

Strengths	**Gaps**
By law in Tanzania it is the duty of local governments to provide for the health and safety of the public. EMA and its regulations contain several provisions for public and worker safety, which are consistent with OP/B P 9.00. The ESIA process involves robust procedures for worker safety, requiring plans for accident prevention as well for health and safety of workers and communities, which are also part of contracts for civil works. Tanzania has a ***Contractors Registration Board*** (CRB) that monitors and enforces occupational health and safety regulations. The Rules of Conduct require that contractors must maintain accident registers, provide workers with protective gear, and standards in construction sites.	Public and worker safety are adequately covered in the EMA regulations and the CRB, and no major inconsistencies between the system and Core Principle 3. However, the worker safety provisions are not always included in civil works contracts. Other gaps identified in Core Principle 1 are also applicable to Core Principle 3.
Actions and Opportunities	**Risks**

The opportunities and actions identified for strengthening the system for Core Principle 1 are applicable to Core Principle 3.	The risks identified for strengthening the system for Core Principle 1 are applicable to Core Principle 3.

*Core Principle 4: Land Acquisition***:** Land acquisition and loss of access to natural resources are managed in a way that avoids or minimizes displacement, and affected people are assisted in improving, or at least restoring, their livelihoods and living standards.

Key Planning Elements*:* PforR Program Systems will:

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

The Core Principle No. 4 is Applicable

Summary Findings:

In case where construction and upgrading of health facilities take outside the existing health facilities (areas) it might require land take from private individuals, institutions and or other government institutions. However, based on experience in similar health projects there has been no relocation or other related impacts. Similarly, loss of access to natural resources is also a low risk. This principle is therefore partially applying to the Program.

Actions and Opportunities	Risks
Technical Guidance and Implementation Capacity: Because the Program is not expected to lead to involuntary resettlement and compensation, in the present Program, focus on: (i) preparation of proper temporary relocation plan; dissemination of the plan to the facility users (ii) provide training and awareness through consultations and media on grievance redress/conflict management, etc.	The risk is low since there is no land acquisition and its related impacts in this program.

In case land take happens, Tanzania has clear land laws, policies, and regulations to guide the process: The land acquisition and compensation including their dispute resolution and grievance mechanisms are governed under the following land laws and regulations. • Land Acquisition Act, Cap. 118 (R.E 2002); • Land (Assessment of the Value of Land for Compensation) Regulations (2001); • Land (Compensation Claims) regulations (2001); • Courts (Land Disputes Settlements) Act, Cap. 216 (2002).	

Core Principle 5 - Indigenous Peoples and Vulnerable Groups: Due consideration is given to cultural appropriateness of, and equitable access to, program benefits giving special attention to rights and interests of Indigenous Peoples and to the needs or concerns of vulnerable groups.
Key Planning Elements*:* PforR Program Systems will: • Undertakes free, prior, and informed consultations if the indigenous people are potentially affected (positively or negatively) to determine whether there is broad community support for the program. • Ensures that Indigenous Peoples can participate in devising opportunities to benefit from exploitation of customary resources or indigenous knowledge, the latter (indigenous knowledge) to include the consent of the Indigenous Peoples. • Gives attention to groups vulnerable to hardship or disadvantage, including as relevant the poor, the disabled, women and children, the elderly, or marginalized ethnic groups. If necessary, special measures are taken to promote equitable access to program benefits.

The Core Principle No. 5 is Considered Applicable

Applicability and Summary Findings

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

While considering the applicability of this Core Principle, the analysis found that it is relevant to ensure that vulnerable and marginalized groups are included in the planning process (especially needs prioritization), implementation and monitoring of program activities; that vulnerable groups have access to program benefits; and that the needs of vulnerable groups are considered with respect to the Programs impacts.

For the ESSA analysis of vulnerable groups focused on those defined in the Tanzania Participatory Poverty Assessment: children, persons with disabilities, youths (unemployed, females, youths with unreliable incomes), people living with long illnesses (e.g. HIV/AIDS, TB, etc.), women (Female headed households, widows and those who are not able to support themselves), young people who are drug addicts and alcoholics. The approach of the Government is to ensure that all vulnerable groups are consulted and benefit from Government programs.

System Strengths	Gaps
The ESIA process in Tanzania does take into account social issues in screening, impact assessment, and mitigation measures. Part of NEMC's screening criteria for ESIAs is to assess if impacts vary by social group or gender, and if resources are impacted that vulnerable groups depend upon. Additionally, there is currently an initiative within NEMC, supported by donors to better mainstream social issues such as gender and HIV/AIDS in the ESIA process. Tanzania also has policies specific to vulnerable groups such as the National Gender Policy and National Policy on HIV/AIDs, in order to prevent discrimination and promote equity. There is also strong guidance for community participatory planning by PO- RALG through the "Opportunities and Obstacles to Development Handbook", which promotes inclusion of vulnerable groups throughout the planning process. Such process is followed by the Tanzania Social Action Fund (TASAF) to support the poor in participating communities across the country.	The analysis identified a number of critical gaps in the system as written, including: ***Identification of Vulnerable Groups:*** Vulnerable and marginalized groups are not explicitly included in the screening process for ESIA through EMA or in the Tanzanian system for land acquisition and resettlement. ***Indigenous Peoples:*** As mentioned above, there is no system in place that defines Indigenous Peoples in Tanzania. ***Social Accountability Mechanisms*:** Weak health facility committees and in some cases their inexistence affect progress in the achievement of inclusive consultation, monitoring and feedback outcomes. ***Monitoring***: Monitoring of gender and women inclusion, poverty, and HIV/AIDS as well as prevention and cure in the development planning process is in need of strengthening. In the health sector there is no common

	method of analysis and collection of baseline to aid development planning on these issues.
Actions and Opportunities	**Risks**
Technical Guidance and Implementation Capacity: While there are some criteria for vulnerable groups in the ESIA process, these need to be strengthened. If requested by the Government, the project may support the current undertaking by NEMC to better mainstream gender and HIV/AIDS in the environmental and social assessment process. ***Addressing Resource Constraints:*** It is unclear if any staff in the health sector is trained to provide inputs on identifying, consulting with, and assisting vulnerable groups that may be impacted by the types of activities that will be financed with the Unreached People Group (UPG) and/or promoting social inclusion in the development planning process. The Program capacity building and training plan can include measures for good practices on inclusive consultations, monitoring and feedback of all groups of people. **Higher Order Opportunities:** The Bank is currently discussing its policy regarding Indigenous peoples with the Government. As the ESSA is intended to be a living document the results of these discussions will be incorporated as relevant once completed.	It is clear from the analysis that, if the gaps identified and opportunities presented in this core principle (where applicable) are not addressed, the Program will be at the risk of not generating the desired environmental and social effects and would remain inconsistent with the guiding principles of Bank Policy - Program-for-Results Financing.

Core Principle 6: Social Conflict*:* Avoid exacerbating social conflict, especially in fragile states, post-conflict areas, or areas subject to territorial disputes.

Key Planning Elements*:* PforR Program Systems will:

Considers conflict risks, including distributional equity and cultural sensitivities.

The Program will not entail social conflict in fragile states, post-conflict areas or areas subject to territorial disputes, nor will the Program cause social conflict or impact distributional equity or associated cultural sensitivities. As such, the ESSA did not consider the Program with regard to Core Principle 6 as this Core principle and key element are not applicable to the Program. It is important to note that, distributional equity and cultural sensitivities are covered under the analysis of system with respect to the main considerations of Core Principle 5.

Bank Directive for Program for Results Financing*:* Considers conflict risks, including distributional equity and cultural sensitivities.

The Core Principle 6 is Not Applicable

The Program will not deal with social conflict in fragile states, post-conflict areas or areas subject to territorial disputes, nor will the Program cause social conflict or impact distributional equity or associated cultural sensitivities. As such, the ESSA did not consider the Program with regards to Core Principle 6 as this Core principle and key element are not applicable to the Program.

STRENGTHS	WEAKNESSES
Existence of procedures guiding public participation and consultations (EMA Act 2004) from the onset of project development will minimize social conflict. The Government of Tanzania also has adopted policies that advance gender equality and youth inclusion in a supportive enabling environment.	
OPPORTUNITIES	
• There is a commitment at the national levels to encourage utilization of local labour so as to empower the local communities during the implementation of the programme. • Training on the applicability of these principles to the program • Development of robust stakeholder management strategies within the systems as part of the current effort to strengthen and systematize projects consultation processes and grievance redress mechanisms	

• Integrate contractual obligations in the legal agreements and contracts for contractors to take responsibilities of the social risks, with appropriate mechanisms for addressing compliance • Presence of Government officers from the National Security agencies that encourage dialogue in dispute resolution as well an avenue for social conflict resolution.	

SECTION VI: STAKEHOLDERS CONSULTATIONS

6.1 Introduction

The ESSA process involved extensive consultations with stakeholders. The consultations mainly aimed at (i) assessing the environmental and social conditions and the institutional capacity to manage the environmental and social risks/impacts; and (ii) meeting with government agencies, Development Partners, and other relevant people/institutions. The discussion mainly revolved around issues related to the stakeholders' perception of the project and its benefits and/or disadvantages, the environmental and social issues that they think are important to be considered by the Project Implementation Unit, and what should be done to handle potential environmental and social issues. Findings from the consultations have been integrated to inform ESSA for revision of the program Action Plan.

Given the health observations aiming to contain the spread of COVID 19, four out of the eight prioritized regions including Pwani, Dar es Salaam, Morogoro, and Dodoma were consulted. Eight facilities were physically visited, and their administrative heads were consulted for their views on the RMNCAH -N program. These include Tumbi hospital, Mkoani Health Center- Kibaha, Morogoro Referral Hospital, Chambalo Dispensary, Kibedya Dispensary, Chakwale Dispensary and Gairo Health Center. In these facilities, consultations were held with the Kibaha Regional Medical Officers (RMO), Maralia Malaria Coordinator (Kibaha), the Kibaha Regional Environmental Officer, and the Chemba District Health Officer.

In addition, the ESSA Team conducted meetings and discussions with *implementing institutions and other relevant partners including:* the Managing Director, Tanzania Food and Nutrition Centre (TFNC); the Ministry of Healthy (MoH); Social Welfare officer PO-RALG; the Muhimbili National Hospital; the Association of Gynecologists and Obstetricians of Tanzania (AGOTA); Centre for Counselling, Nutrition and Health Care (COUNCENUTH); the Program Manager Advocacy and Disability Inclusive –CCBRT; and White Ribbon Alliance for Safe Motherhood in Tanzania. A full list of the stakeholders consulted is presented in appendix 2 and 3.

Generally, no significant negative environmental or social impacts are envisaged by stakeholders through the RMNCAH -N program. The stakeholders mentioned minor and temporary negative impacts arising from construction-related activities. More positive social impacts are envisaged such as enhanced facility waste management systems, provision of equipment and administering of capacity building training to the staff on E&S. No significant impacts on indigenous people are envisaged. The key observations and issues raised on the environmental and social impacts of the RMNCAH -N program are as follows:

(a) Inadequate waste disposal infrastructure at health facilities at all levels (national, regional, district and primary) manifested through:

- Lack of facilities for proper management of Medical waste (Incinerator, Sewage system, Sewage ponds as well as laboratory/theatre /labor Waste products)
    - Lack of well-functioning primary health centres in the vicinity of settlements. It was found that the incinerators found in various hospitals have no adequate capacity to properly dispose HCW, which means they have weak efficiency. It was noted that they are under capacity, do not perform well, and cannot capture emissions, except only one in Itigi Hospital (Singida) which was noted to be efficient. The Project shall target

upgrading of waste disposal infrastructures to reduce the risk of infectious diseases born from the existing poor medical disposal systems.

- Low capacity of staff on E&S (waste management)
- Poor or lack of trucks for transferring medical waste from primary health care to the disposal facilities.

(b) *Lack of institutional arrangement regarding disposal of healthcare waste.* There are no specific regulations for disposal of healthcare waste in place yet. If such regulation were in place, they could have guided the institutional arrangements for waste disposal.

(c) *Lack of operationalization of Health care waste management guidelines.* The guidelines and detailed standards were prepared and disseminated through a directive to lower levels as far as Health Management teams since 2006, but not implemented.

(d) *Facility designs for existing health facilities do not enable hygiene practices*. This includes absence of basic needs like water and sanitation facilities.

(e) *MOHSW has authority to deal with HCWM issues*, and a National Program for HCWM was set up in 2006 and is headed by a National Coordinator. However, low capacity levels and inadequate resources have hampered the effectiveness of the implementation of the program, and hence considerable effort is needed to ensure compliance with the appropriate global practice in waste management at PHC facilities.

(f) *Shortages in health facilities that provide Adolescent reproductive health education:* the majority of stakeholders reported that health facilities that provide reproductive health education are rare due to financial constraints. Stakeholders expressed their discontent with the provision of contraceptives to young girls to prevent early pregnancies. Based on their concern, emphasis has to be placed on educating both young girls and boys instead. As well, the one-stop centres which provide health facilities for to handling SGBV cases were reported to scarce. The service offered at one stop centres has been proven to be useful but the ministry has no funds to reach out many adolescent /youth and children with such services due to shortage of funds.

(g) *There is lack of awareness in people about environmental and social issues in construction works*. The Program will include an awareness and information dissemination component to address this issue.

(h) With regard to the social risks and impacts associated with land acquisition, the stakeholders said that there will mostly be minimal need for land acquisition for development of health facility infrastructure. This is because, the need for land to be used for health facility expansion would be required only where the existing project land or plot sizes are small, but in other areas where space is available, the probability of land acquisition is very minimal. It was reiterated that new buildings are developed (or proposed to be developed) within the existing surveyed plots in most cases, as has been the practice with the EPfR-supported projects in the past two years. Where necessary, conflicts arising from forced acquisition or poor compensation are unlikely. This is because Local Government Authorities in respective areas secure the right of ownership of such health facilities and negotiate with the surrounding communities on the same. In addition, municipal councils in Tanzania usually follow government procedures in acquiring land from communities, either

through official purchase and compensation, or through community designation of areas willingly/and according to land use planning. The Land Policy (1999) and Village Land Policy (1999) are normally referred to in such cases.

Summaries of other concerns, comments, suggestions and issues discussed and information provided during the various interviews and field visits are presented in Tables 8, 9 and 10:

Table 8: Regional and District Level Health Facilities Consultations

Issues Raised	Response
Where are **incentives** in the program? Some of the issues identified are a result of absence of an incentive structure to help the health staff to cope with the poor environment they are working in. Some programs have compensatory measures for staff.	The Program will work within the existing government systems and structures. Compensation is a government responsibility. The responsibility will be with the health facility to identify measures to put in place in order to achieve the indicators of performance.
In addition, **shortage of qualified specialists** in the health facilities is also quite a challenge.	With performance incentives in place, the likelihood is that about 70% of the resources earned by the health facility will be spent. Then, the health facility will decide how to use the remaining 30% in a participatory and transparent manner.
Facility designs for existing health facilities are not supportive to hygiene practices. This is attributed to the absence of basic needs like water and sanitation facilities. How will the program help?	The program will require the health facilities to identify their challenges. Then it will help the facility management and the responsible council and governing committee to find ways of addressing the challenges using the available resources. There will be small works to improve the facility or make it more functional, for example installation of a rain water harvesting system may be undertaken by the facility to improve hygiene. The program will not finance civil works for new buildings or ancillary facilities.
Guidelines for the **composition of health facility committees with representation of community, women, staff,** etc. have been issued. Some facilities have them and are working well while others do not. However, their working also depends on the in-charge (is also the secretary of the committee) who must be cooperative even though the BRN program urges health committees to be active. The surrounding communities are at the center of this change. Issuing directives is not the answer. Committees must be resuscitated and communities informed of whatever is going on. The responsibility of the committee is also to build	This was a suggestion to be considered to include community engagement in the health council plans if not already done.

Issues Raised	Response
capacity of its members and the community served by the facility.	
The government has for some time procured **equipment** for primary healthcare facilities, which has become obsolete and needs to be disposed-off. Is this included in the waste management plan	The decision to dispose of used the equipment is up to the health facility and the relevant authorities. If the waste is significant, this can be one of the issues to be discussed by the facility so as to reach a decision in a participatory and transparent manner.

Table 9: Issues from representatives of Ministries and Government Institutions

Issues Raised	Response
Enhanced capabilities of the Community Development department, to ensure adequate administering of awareness /sensitization sessions to community on family planning, adolescent health. Campaigns against physical and sexual violation.	This is well provided for in the CHSB guidelines for both trainers and establishment. They are distributed to all councils. This program will scale up efforts to orient communities to these guidelines. This is reflected in ESSA.
Enhanced data collection and reporting system and E&S monitoring framework,	The Program provides for enhanced monitoring of which data collection will be a pivot of the process.
Mainstream the E&S activities in the M**inistry of Health Plans** to ascertain ownership for sustainability.	The health facility has to decide how to use a percentage of the funds it has obtained for streamlining E&S aspects. However, this has to be done in a participatory and transparent manner.
Inadequate one stop centers to handle issues associated with GBV and other complaints. Currently, there are 14 one-stop services centers over 184 councils around the country. What is sought is the possibility for this project to support the Ministry of Health in establishing one-stop centers in every facility that will covered by the project.	The program will support these existing initiatives to enhance adolescent and children reproductive health
Supporting government efforts in infrastructure development and human resource capacity building.	It is among the program objectives that the government will be supported
Upgrading of waste disposal infrastructures will reduce the risk of infectious diseases born from the existing poor medical disposal systems.	Noted. The objective of the project is to ensure proper management of the medical waste in various ways including provision of waste disposal facilities. E&S will carry out capacity building to the existing systems to enhance supervision of medical waste disposal.

Improved access to social welfare services especially prevention/handling gender - based violence and violence against children. It is anticipated that the project will establish one stop centers in health centers to address GBV in that context victims of GBV, child abuse and defilement will receive multiple services at one convenient point.	Strengthen awareness on GBV and operationalize GRM.
ESSA will facilitate the establishment of guidelines to ensure inclusion of specific needs of marginalized groups in the designs of infrastructures, procurement of fixtures and as well as listening to their voices through consultations.	
Environmental risks due to temporary disturbance during construction phase: the stakeholders raised a concern that, since construction activities are going to be to be conducted in the existing health facilities, it is likely that there will be some disturbance due to dust and noise nuisance. In addition, the possibility of competing uses of health facilities (water sources, toilets) between the health facility patients'/staff population and construction workers is likely to be experienced. However, no major environmental impact such as water pollution or complete damage of the landscape and natural vegetation is not envisaged since such constructions are often done within the plots of the existing health facility, which have already been secured.	ESMP will be designed during construction

Table 10 Issues Raised by the NGOs & CSOs

Issues Raised	Response
Project context	
Project should consider provision of diagnosis equipment for BP and Hemoglobin as part of strategy to reduce the risks associated to maternal deaths.	Noted. The suggestion has to be taken on board during project implementation.
Results 1: Should exclude the group under 18 from the use of contraceptives for family planning. Alternative measures to prevent early pregnancies other than contraceptives should be sought	Noted. Emphasis has to be made on one stop centers to enhance provision of reproductive health education programs to adolescent girls and boys.
Prepare disability service guideline.	Will be taken on board in the POM
For sustainability of the project it is necessary to create a synergy between the ministry of health, NGOs and private sector.	The implementation framework of the project lies on this line. To be included in the PIM
IFA Supplies and utilization. We understand how important the service is in preventing and addressing maternal anemia, LBW, and stunted growth. The ministry should promote health financing as well as	Noted. For implementation in the PIM

Issues Raised	Response
promote utilization of the same so as to increase number of attendees receiving recommended quantity of IFA tablets.	
Project to allocate some funds for advocating this project in the local government Authorities, through which the LGAs will be required to allocate domestic money for family planning. WB should periodically (or through NGOs) assess the allocated funds for family planning and emergency response.	Noted to be included in the PAD
Project would include provision of: guidelines for malaria prevention to pregnant mothers, COVID vaccination guidelines in pregnancy. Safe family planning immediately after delivery. *This can be done in collaboration with NGOs with similar core activities*	Noted be included in all relevant project documents
Nutrition aspects to be considered in the project which target improving maternal, neonatal and adolescent health. This can be achieved through a well-established linkage with NGOs that deal with nutrition especially those advocating breast feeding, food production and food consumption.	Noted be included in the PAD
Environmental and social risks	
Ensure good working environment for health workers, currently most health facilities are working under difficult environment. Provide contraceptive and medication services to women to save them from getting unplanned pregnancies.	Noted.
Availability of Human resource for E&S	
National health structure recognizes social workers; however, their roles should be clarified.	E&S aims to strengthen capacity of E&S staff. That will include defining workers' roles and responsibilities.
NGOs working in the health sector have social workers who disseminate information, attend GBV cases, children abuse / defilements reporting and cancelling the victims/survivals.	Noted. The framework be incorporated in PAD and PIM
To reduce maternal death, the project is advised to use mentorship approach to enhance the capacity of health workers.	Noted for incorporation in the specific capacity building program.
Promote Health insurance for the pregnant/ expecting mothers that will cover for their new born.	Noted. Be incorporated in the consultation and capacity building program.

Issues Raised	Response
Project to ensure that people with disability are equally given a first priority in receiving project benefits.	Information reflected in the ESSA and will be monitored.

6.2 Multi-Stakeholders Consultations Meetings

The World Bank Safeguard Team conducted stakeholders' consultation meetings on RMNCA-Health Services. The meetings were held from 21st to 23rd March 2022 through a Hybrid Method (Virtual and Physical Meetings). The overall objective was to share the draft Environmental and Social Systems Assessment (ESSA) document and findings to the key Stakeholders and thus provide space for them to give their comments, suggestions and concerns. The consultations were attended by participants from Academic Institutions; Health service practitioners; Donors, International NGOs & local NGOs dealing with health; organizations dealing with people living with disabilities; and Government officials, Regulatory authorities and Ministries.

The consultations aimed to seek stakeholders' contributions on how RMNCA-Health Services can be implemented without adversely affecting the environment and people. The key areas for consultation were: stakeholders' perception of the project; environmental and social issues relevant to the programme; potential threats/risks or challenge associated with the program; steps to be taken to address those threats/challenges; the role stakeholders can play during execution of the program; environmental and social programs that should be executed by the project implementers; stakeholders' specific needs to be considered during project designs or in the implementation process; and steps to be taken by the project implementers to enhance the grievance handling.

The findings from field visits to health facilities, from healthcare workers, from implementing institutions and from other relevant partners were largely consistent with those from multi-stakeholders' consultations meetings. Generally, the stakeholders highly commended by acknowledging that it will expand and improve the quality of healthcare services in Tanzania. They also agreed with the ESSA's findings and the proposed actions to address the social risks and impacts anticipated to result from the programme. A summary of the key observations, comments, concerns and suggestions are presented in Table 11:

Table 11 : Multi-stakeholders' key observations, comments, concerns and suggestions

S/N	Question/Comment	Response
1.	The project to devise indicators for tracking its performance on environment and social (E&S) issues.	Agreed, the project E&S personnel at different levels of implementation will observe E&S issues as it will be stipulated in the ESMP
2.	The project to enhance awareness of COVID-19 vaccination.	Agreed, PIU will mainstream COVID-19 issues during project implementation and raise awareness among project workers and other stakeholders
3.	Currently, the management of medical waste in Tanzania is a challenge. The	The project will refurbish selected health facilities and provide incinerators in the facilities where need is identified. The

	project should consider provision of incinerators	project will support measures to strengthen to manage health care waste.
4.	Education initiatives on Reproductive Health and Family Planning carter mostly for school children. What measures are available for assisting out-of-school children?	The government and partners support various services for adolescent health through adolescent/youth clubs/centers in the districts and communities. In addition, there are ongoing initiatives on promoting health facilities to provide adolescent friendly services. The project will support these existing services through the HBF.
5.	There is shortage of human resources in the health sector, especially in the nurses' cadre. How is the project prepared to address this?	Through this project, the government will recruit nurses, train pre-service nurses as well as train in-service nurses in specialized services as well as build capacity to deliver quality services through coaching and mentorship programs.
6.	The project could also consider the issue of nutrition because it highly affects infants and mothers. The project could do this by providing simple nutrition guidelines and leaflets to mothers.	The project in its design will support nutrition interventions both in Zanzibar as well as the mainland.
7.	The project to also target provision of Basic Hand Washing facilities to improve hygiene.	The project through the HBF will support services directed to environmental health and hygiene with a focus on raising awareness and providing WASH facilities in health facilities undergoing refurbishment. These will be done in close collaboration with the water sector.
8.	How is the project prepared to deal with issues of Gender Based Violence (GBV) in health facilities? There is a tendency of hiding such cases and the GBV victims are not aware of the appropriate measures to take.	The project will develop a mechanism to deal with GBV and Sexual Exploitation and Abuse (SEA) cases so as to avoid the possibility of the project to escalate these problems.
9.	How is this project prepared to deal with issues of gender and economic empowerment of women?	The project does not target women empowerment in terms of economic development.
10.	The project to consider generation of data through the health care continuum – for example what exactly cause the death of newborns?	The information is already available in current HMIS system which the project will use.
11.	○ How does the project design consider the Tanzania Disability Act?	○ The design of health facilities to be constructed under this project will take into account the provision for PwDs.

	○ How will the project accommodate Civil Society Organizations (CSOs) working with People with Disabilities (PwD)?	○ PwDs will be consulted throughout the project cycle and they will be made aware of the project benefits.
12.	How best is the project prepared to improve working environment in health facilities as part of E&S?	Health and Safety are part of the ESMP matters and will be intergraded during the construction and the other phases of the project.
13.	Project to consider inclusion of CSOs who work with PwDs during project monitoring and evaluation.	The project will use the SWAP arrangement which involves different groups of CSOs both at national and sub national levels.
14.	The ESSA document to take into consideration the national public health policies, strategies and guidelines on management of healthcare waste.	The ESSA Team have reviewed and accommodated directives and provisions as included in the following national public health policies, strategies and guidelines: ○ National Policy Guidelines for Health Care Waste Management in Tanzania (2017). ○ The Public Health Act was enacted in 2009. ○ National Guidelines on HCW management ○ National Strategic Plan for Health Care Waste Management (2018 -2022). ○ The current Health Care Waste (HCW) Management Practice in the Healthcare Facilities of Different Levels in Tanzania (2021).
15.	The project to come up with suggestions on how to avoid or minimize construction impacts especially on grievances related to payment of unskilled laborers, food vendors and toilets.	The contractors will be introduced to the basics of Employment and Labour Relations Act, Act No. 6 of 2004, and the Workers Compensation Act, 2008, and importance of observing rights of local Communities.
16.	The design of healthcare facilities to include/ be supplied with supportive facilities that enhance hygiene practice (e.g. washing facilities, toilets, water storage tanks (reservoirs), bathrooms, tiles, septic tanks etc.).	Agreed. Facilities' floors to be covered by tiles for easy cleaning.
17.	PforR program does not support project activities which lead to significant land acquisition and/or resettlement of a scale or nature that will have significant adverse impacts on affected people or the use of forced evictions. How is this principle	In implementing this principle, the Bank doesn't define fixed numerical thresholds for the term "large" because the significance of the impacts depends very much on local contextual factors. The definition of significant resettlement

	related to our project since sometimes the facility can acquire up to 100acre?	impact is closely related to the extent to which the client's (Borrower) systems align with the core principles and to the borrower's capacity to carry out land acquisition and resettlement in accordance with policy principles and requirements. Therefore, emphasis is placed on the potential significant impacts on the affected people regardless of scale. Henceforth, what is required is for the Borrower to demonstrate the capacity to undertake resettlement in accordance to PforR principles.
18.	The WB should be flexible when it comes to monitoring health projects which are constructed under force account (FA). The FA in most cases makes use of 'local fund's and often do not mainstream Covid-19 protocols and use of Personal Protective Equipment (PPE).	○ Protection of workers' health and safety is priority number one to both GoT and WB. Therefore, any construction which endangers peoples' health and safety cannot be tolerated. ○ All RMNCAH -N projects to be registered with OSHA so that they get the required inspections and directives on how to ensure health and safety. ○ OSHA should be one of the Institutions involved in the implementation of the ESMP and the Monitoring Plan.
19.	Management of Health Care Workers are hampered by lack of coordination between the Ministry of Health (MoH); President's Office – Regional Administration and Local Governance (PO-RALG); and lower levels. How is the project prepared to handle this?	The roles of both MoH and PORALG are quite clear. The project will have Steering committee to bridge the perceived gap in coordination. The committee will oversee all multisectoral issues including human resources for health. The project will support measures to strengthen the capacity of the HRH both in-service and pre-service at all levels.
20.	Health facilities face security challenges because they lack fences that could limit interactions with outsiders. How is the project prepared to handle this?	Where there is a need the project will support selected health facilities undergoing refurbishment to construct fences which is key for security purposes.
21.	One of the anticipated project risks and impacts is GBV and SEA; STDs, HIV/AIDs. How is the project prepared to protect civil workers and local population against such evils?	The following will be done: ○ Contractors in collaboration with PIU will prepare a code of conduct in relation to GBV issues so as to protect civil workers and the local population. Every project worker and contractor will be required to sign the code before employment placement.

		○ Community sensitization and awareness on GBV and SEA; STDs, HIV/AIDs will be undertaken throughout the project cycle. Also, the community will be made aware of the Grievance Redress Mechanism for GBV/SEA. ○ During preparation of the code of conduct, consideration will be made on national strategies e.g. The National Plan of Action to End Violence against Women and Children in Tanzania 2017/8-2021/2 (NPA-VAWC 2017/18 – 2021/22). ○ Make use of Policy Gender Desk in orienting stakeholders on GBV issues.

Disclosure of the final ESSA will be carried out through face-to-face meetings as well as virtual communication with National and Regional levels participants, invitations will be sent to all relevant Ministries and department representatives and other relevant stakeholders such as Civil Society Organization (CSOs) and development partners to give comments on the draft ESSA report. Although not obliged, the comments from stakeholders incorporated in the final ESSA report shall be disclosed on the client's website before appraisal of the program. Document Dissemination and Public Comments Period: The final ESSA will be publicly disclosed and shared with the donor partners and stakeholders involved with environmental and social management issues in Tanzania. The final report will also be translated into Swahili and disclosed publicly as well as in Infoshop. The World Bank will also disclose the ESSA report on its external website.

SECTION VII: RECOMMENDED MEASURES TO STRENGTHEN SYSTEMS PERFORMANCE

7.1 System Performance Strengthening

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

The analysis identified the following main areas that need action in order to ensure that the Program interventions are aligned with the Core Principles 1, 3, and 5 of OP/BP 9.00: Health Care Waste Management and Social Accountability. These could be further defined during the consultation process and during the implementation, as required. The ESSA, therefore, proposes some key measures to be taken for improved environmental and social due diligence in the Program as presented in Table 12. These measures to improve system performance shall be included in the Program Action Plan for implementation.

Table 12: Measures to Strengthen System Performance for ESM

Objective	Measures	Timeframe	Responsibility	Instrument
Ensure effective implementation of the Tanzanian environmental and social management system for the PforR program related to management of Health Care Waste (HCW)	○ Increase capacity of waste disposal infrastructure at health facilities at all levels (national, regional, district and primary). ○ Strengthen the capacity for monitoring, supervision and enforcement of national guidelines on HCW management ○ Operationalize the existing HCW management guidelines ○ Include HCWM and Community Engagement plans in the Comprehensive Council Health Plans (CCHP) to improve HCWM. ○ Update technical guidance for better waste management (health care and construction), asbestos and incinerator management, occupational safety and hygiene practices.	Within 1 year of project effectiveness	MoH, WB	○ Training materials and schedule. ○ Training given to the PIT and Healthcare providers ○ Put in place technical guideline for HCW management ○ Updated technical guidelines on HCW management; asbestos and incinerator management, occupational safety and hygiene practices. ○ Carry out a needs assessment/feasibility study to ascertain the capacities and conditions of existing incinerator at relevant health facilities to guide intervention. ○ Follow-up on the implementation of the HCWM to be a part of

Objective	Measures	Timeframe	Responsibility	Instrument
				World Bank Technical Supervision mission.
Increase coordination among various ministries, agencies and donor partners on environmental and social aspects.	The Program to avail more information to the public; and improve coordination among various ministries (led by MoH), agencies and donor partners in respect to environmental and social aspects to further support implementation; and information sharing through publicly available mechanisms. The measures to improve information disclosure and stakeholder consultations will be included in the Program Operations Manual.	Continuous	MoH &LGAs	Progress report
Protect project workers, local communities, and vulnerable groups against labour exploitation, GBV/SEA, STDs, and COVID-19.	○ Maintain effective collaboration with OSHA and Ministry of Labour and Employment on health, safety, and labor management issues. ○ Develop and Operationalize the Workers' code of conduct including GBV/SEA prevention and response. ○ Mainstream Ministry of Health COVID-19 Management Protocol in all civil works and public consultation and engagement. ○ Enhance existing mechanisms for grievance redress and complaint handling.	Continuous	MoH, OSHA, LGAs, Ministry of Labour and Employment.	Progress Report
Enhance transparency and information sharing, grievance redress, and community participation.	○ Ensure inclusive and participatory consultations and feedback for social accountability along with improved focus on gender and other vulnerable groups also need improvement.	Continuous	MoH &LGAs	Progress reports
Addressing Capacity Constraints	ESSA recommends capacity building and training actions for improved implementation, including infection control, waste management, how to administer social accountability mechanisms, and	Within one (1) year of project effectiveness.	MoH	○ Updated technical guidelines on HCW management. ○ Training schedule.

Objective	Measures	Timeframe	Responsibility	Instrument
	grievance redress. These will be integrated in the Program's capacity building plan. Provide capacity buildings on HCWM to E&S workers health facility levels			○ PIT and other Relevant Health Care Providers to get trained on HCW ○ Progress reports
Ensure that the designs of the existing health facilities are supportive to hygiene practices.	The Health facilities to be constructed/upgraded to be supplied with supportive facilities that enhance hygiene practice e.g. washing facilities, toilets, water storage tanks (reservoirs), bathrooms, tiles, and septic tanks.	Throughout the project cycle.	MoH, WB	○ Field supervision ○ Progress Reports.
Improved systems for Information Disclosure and Stakeholder Consultation to ensure that the benefits of the Program reach all beneficiary groups (service users and providers).	The Program to avail more information to the public; and increased coordination led by MoH among various ministries, agencies and donor partners on environmental and social aspects to further support implementation; and information sharing through publicly available mechanisms. The measures to improve information disclosure and stakeholder consultations will be included in the Program Operations Manual.	Throughout the project cycle.	MoH, WB	○ Project implementation manual to have a section on how project will accommodate vulnerable groups to ensure they benefit from the project. ○ Make use of the Government Open Data Partnership and other information disclosure aspects. ○ Progress reports.
Ensure land is acquired in accordance with Tanzanian land laws.	Confirm that acquisition of land is consistent with the Tanzanian land laws.	Before commencement of construction	MoH, LGAs and WB	○ Social Due diligence ○ Field Supervision reports

Objective	Measures	Timeframe	Responsibility	Instrument
		of health facilities.		

REFERENCES

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

1. National Bureau of Statistics. Tanzania Demographic and Health Survey, 2011.
2. Zanzibar Health Budget Brief 2019/2020
3. World Bank, Health Sector Public Expenditure Review 2019
4. Household expenditures derived from the 2014/15
5. Household Budget Survey and analyzed using the Consumer Price Index for health products for 2017/18.
6. Mid Term Review Report, Health Basket Fund, March 2020
7. HBF in the mainland in 2020/21 received funds from 8 donors - 5 bilateral (Switzerland, Denmark, Canada, Korea, and Ireland) and 3 multilateral agencies (World Bank, UNICEF and UNFPA).
8. HSSP V (2021 -2026) for the Mainland, and HSSP IV (2020 – 2025) for Zanzibar
9. Mainland National Health Policy 2007 and Zanzibar Health Policy 2011
10. Tanzania mainland - HSSP IV (HSSP IV 2015 - 2020), Zanzibar – HSSP III 2013/14-2018/1969
11. Office of the Vice-President. Fifth National Report on the Implementation of the Convention on Biological Diversity. Environment Division. 2014.
12. World Bank. Qualitative Social Assessment Report –Tanzania Results based Financing Project, 2014.
13. URT. MKUKUTA II. Poverty and Human Development Report. 2011.

ANNEXES

Annex I Environmental Impact Assessment (EIA) Process in Tanzania

The key steps of the EIA process are:

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

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

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

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

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

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

Environmental Decision-Making: After submission of the final version of the EIS, NEMC assesses it in order to ascertain whether all the TAC comments and recommendations have been adequately addressed

by the consultant. Thereafter, terms and conditions for issuance of the EIA Certificate are prepared by NEMC. Approval/disapproval of the EIS is done by the Minister responsible for Environment as stipulated in EMA 2004 section 92 (1).

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

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

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

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

Annex II List of Persons Consulted

The following is a list of stakeholders who participated in the first virtual meeting held on 7th Dec 2021.

List of Government Ministries and Institutions				
S/N	**Institution**	**Name**	**Mobile**	**Email**
1.	Vice President's Office (VPO)	Mr. Onesphor Kamukuru	0719 062 090	okamukuru@gmail.com
2.	National Environment Management Council (NEMC)	Mrs. Redempta Samwel	0784 508 062	rsamwel495@gmail.com
3.	MoHCDEC)	Christabella Ngowi	0713 375 077	christabela.ngowi@jamii.go.tz ngowic@gmail.com
		Anietus Honest Environment	0754 311 115	ahonest2000@yahoo.com
4.		Adolf Kiyunge- Social	0713 664 544	akiyunge@gmail.com
5.	MHCDGEC	Joseph Birago - Environmental Health, Hygiene and Sanitation Section.		birago76@yahoo.co.uk
6.	MoHCDEC - RMNCAH -N	Dr. Ahamad Makuwani		amakuwani@gmail.com
7.	MoHCDEC	Dr. Khalid Massa		kmkmassa@yahoo .com
8.	President's Office- Regional Administration and Local Government (PORALG)	Mariam Mkumbwa- Social	0784 746 352	mariam.mkumbwa@tamisemi.go.tz mumhussein@yahoo.com
		Best Yoram Onesmo- Environment		bestyoramx@gmail.com
9.	Tanzania Food and Nutrition Centre (TFNC)	Dr. Germana Leyna:	0782 847 320	germana.leyna@tfnc.go.tz
10.	Occupational Safety and Health Agency (OSHA)	Dr. Joshua Matiko	0754 295 437	joshua.matiko@osha.go.tz

11.	Muhimbili University of Health and Allied Sciences (MUHAS)	Dr. Nahya Salum, Department of Paediatrics and Child Health,	0713 250 074	nsalim@ihi.or.tz
		Dr. Furaha August, Dept of Obstetrics and Gynecology	Cell: 0754 304 240	drfuraha@gmail.com
12.	MUHAS: Department of Environmental and Occupational Health	Prof. Simon Mamuya		mamuyasimon2@gmail.com
13.	MUHAS: Environmental Health & Sanitation Section	Hussein Mohammed;		hmohameds1@gmail.com
14.	MUHAS	Prof. Projestine S. Muganyizi		
LIST OF NGOs/CSOs				
S/N	**Organization**	**CONTACT**		
1.	Association of Gynecologists and Obstetricians of Tanzania (AGOTA)	Dr. Matilda Ngarina – President:	0713 406 267	mmatty71@gmail.com
2.	Centre for Counselling, Nutrition and Health Care (COUNCENUTH)	Dr. Kissanga:	0682 892 386	lunnakyungu@yahoo.co.uk
3.	Chama cha Walemavu Tanzania (CHAWATA)	Mr. Benjamin Mayengera	0763 155 921 0753 578 467	Bmayengela76@gmail.com
4.	Aga Khan University	Mr. Gamariel Mboya	0754 968 114	gamariel.mboy@aku.edu
5.	Program Manager Advocacy and Disability Inclusive – CCBRT	Fredrick Msigallah	0717 036 241 0754 467 549	fredrick.msigallah@ccbrt.org

6.	Chairman Tanzania Association of the Disabled	Mr. Hamadi Komboza		
7.	Country Representative FHI	Suzan Mwaka	022 260 1395	smwaka@fhi360.0rg
8.	White Ribbon Alliance for Safe Motherhood in Tanzania	Rose Mlay	0754 31 369	Rose.mlay@gmail.com

Annex III: List of Participants & Consulted Stakeholders

Stakeholders' Consultations March 21, 2022				
	Full Name	Organisation	Email	Telephone
Virtual Attendance				
1	Peter Okwero-Senior Health Specialist	WB	pokwero@worldbank.org	0689561960
2	Nahya Salim-HoD Paediatrics and Child Health	MUHAS	nsalim@ihi.or.tz	0713250074
3	Georgina Msemo			
4	Novath Rukwago-Programme Manager	SHIVYAWATA	novatrk@gmail.com	0762406785
5	Prof Simon Mamuya-Environment and Occupational Health Department	MUHAS	mamuyasimon2@gmail.com	
6	Cate Paul-Country Director	NEST360	cp57@rice.edu	0763829984
7	Deogratias Mkembela-Country Director	UNDP	deogratias.mkembela@undp.org	
8	Furaha August-HoD Obstetrics and Gynecology	MUHAS	drfuraha@gmail.com	0754304240
9	Mariam Ally-Senior Economist	WB	mally@worldbank.org	0754436472
10	Honorati Masanja	Ifakara Health Institute	hmasanja@ihi.or.tz	0752312300
11	Neema Clarence-Team Assistant	WB	nclarence@worldbank.org	0784456144
In Person				
1	Rose Mlay	White Ribbon Coalition	rmlay@whiteribbonalliance.org	0754316369
2	Jackline Makupa	Medipeace Tanzania	jackline.makupa@medipeace.org	0754980832
3	Francis Mashulano-Secretary General	Mental Disability Organisation	tamh.tamhhq@gmail.com	0757576443
4	Hamad Komboza-Chairperson	Tanzania Association of the Disabled	hkomboza@gmail.com	0754555031
5	Muke Magoma-Country Representative	EngenderHealth Tanzania	mmagoma@engenderhealth.org	0754284691
6	Dr Chetan Ramaiya -Vice President	AGOTA	chetanramaiya@gmail.com	0789976722

7	Fredrick Msigallah -Programme Manager Advocacy and Disability Inclusion	CCBRT	fredrick.msigallah@ccbrt.org	0717036241
8	Anna J.Temba-Technical Director	EngenderHealth Tanzania	atemba@engenderhealth.org	0756088053
9	Benjamin K. Mayengela	CHAWATA	bmayengela76@gmail.com	0753578467

Stakeholders' Consultations March 23, 2022				
	Full Name	**Organisation**	**Email**	**Telephone**
Virtual Attendance				
1	Peter Okwero-Senior Health Specialist	WB	pokwero@worldbank.org	0689561960
2	Georgina Msemo			
3	Mariam Ally-Senior Economist	WB	mally@worldbank.org	0754436472
4	Joseph Birago	MoH	birago76@yahoo.co.uk	
In Person				
1	Joseph Mwanadyogo-Env. Health Officer	Bahi Town Council	mwanadyoga@gmail.com	0755787408
2	Victor Rugarabamu-SCDO	MCDGWSGS	victorrugarabamu@gmail.com	0652212100
3	Adolf Kiyunge-Principal Env. Health Officer	MoH	akiyunge@gmail.com	0713664544
4	Yahaya R. Hussein-Principal Medical Officer	PORALG	yahayahussein@tamisemi.go.tz	0754372772
5	Josephat Joseph-PO	PORALG	jjosephat89@gmail.com	0766949045
6	Abdallah S. Mahia-City Health Officer	Dodoma City Council	mahiaabby@gmail.com	0758888555
7	Rebeka Ndaki-SWO	Dodoma City Council	ndakirebeka@gmail.com	0784445025
8	Albert Komba-Project Coordinator	MoH	akomba19@gmail.com	0685399047
9	Dr Honest Anicetus-ESS Focal Person	MoH	hanicetus@gmail.com	0754311115
10	Peter Kaswahili-Nutrition Officer	MOH	pkaswahili@gmail.com	0784669381
11	Best Yoram-Env Health Officer	PORALG	bestyoramx@gmail.com	0694369333
12	Paulina Kassim Mbalwa-EMO	GGD	mbalwapaulina19@gmail.com	0710032713
13	Frida Kampinga-PNO	MoH	fridakp@gmail.com	0713666641

Annex IV: Reference to Typical Waste Management and Monitoring Plan

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

Installation of centralized treatment						
Equip all large HCFs with segregation, packaging, collection material (including protective)			MoH		Number of HCF with essential HCWM equipment	
clothes), transportation and disposal equipment						
Conduct awareness campaign Policy makers • Health facility personnel/staff • General Community/population.			MoH		Number of awareness sessions conducted in healthcare waste management	
Provide Technical training for the Health Officers of the MoH, National Institutions (CEDHA, MUCHS,) Regional and District Authorities (train 'trainers of trainers")			MoH /CEDHA		Number of Health officers trained in technical aspects of healthcare waste	
Set-up-in-service Training Programmes in regional Centres for medical, paramedical and technical staff			MoH /CEDHA			
Review curricula in health institutions to incorporate HCWM			MoH /MUHAS/KCMC/BUGANDO		Number of professional curriculum reviewed	
Recruit new staff members at the MHCDGEC SW			MoH		Number of Professionals recruited for healthcare waste management Programme	

Support Regional and District Hospitals with construction of high tech medical waste incinerators.			MoH		Number of HCF with high tech incinerator	
Review and incorporate technical aspects related to provision of water supply and sanitation facilities and hand washing facilities in the Ministry Construction guides for Healthcare Facilities.			MoH		Revised building technical guidelines for the provision of water and sanitation and hand washing facilities	
Establish a National database and information management for HCWM			MoH /UDSM		Database and information management system	
Train Healthcare workers on healthcare waste management and infection prevention and control country wise			MHCDGEC		Number of healthcare workers trained in healthcare waste and infection prevention and control	
Support HCWM Program with office running cost (fuel, Computers,			MHCDGEC		List of items procured to support HCWM programme	
Office consumables)					office	
Develop IEC promotion materials for HCWM.			MHCDGEC		Types and list of IEC materials developed and distributed	
DISTRICT LEVEL and FACILITY LEVEL						
WASTE PRODUCTION AND GENERAL ISSUES						
Develop facility-based plans	LGAs, HMT		MHCDGEC	Continuously during development of plans	Draft and final Plans	

Construct Incinerators	Contractor LGAs MHCDGEC		MHCDGEC	During design and during construction	Approved designs and contract schedules	
Purchase initial supplies for waste management equipment to include safety boxes			LGAs, MSD	Once on making estimates and requisitions. Once after purchase	Purchase requisitions, delivery notes and receipts	
Purchase Occupational Health and Safety /Personal Protective Equipment (PPEs)	LGAs, HMT		MHCDGEC	Once on making estimates and requisitions. Once after purchase	Number and types of PPEs procured	
Procure and install water storage tanks	Contractor		MHCDGEC	Once on making estimates and requisitions Once after purchase During construction	Purchase requisitions, delivery notes and receipts Contract and Specifications	
Develop and implement public social mobilization/ awareness	LGAs, HMT/MHCDGEC		Laboratory Manager	Continuously during preparation of plans and during implementation	Number of people accepting and participating in the project	
Ensure set-up of laboratory is conducive for easy and safe working	Laboratory Supervisor		Laboratory Manager	Monthly	Number of accidents related to laboratory setup	
Availability of appropriate laboratory chemicals / materials to avoid or minimize waste	Laboratory Supervisor		Laboratory Manager	Monthly	Number of items Purchased according to recommended list	
Minimize movement of people in the work area	HMT		Laboratory Manager	All the time	Number of times unauthorized persons found in laboratory	

Use color-coded waste bins in appropriate positions	HMT		Laboratory Manager	Quarterly	Number of bins in recommended places	
Segregation and storage of waste	HMT		Laboratory Manager	Monthly	Number of waste	
into marked bins					streams used	
Place disposable and reusable materials separately	HMT		Laboratory manager	Monthly	Number of cases of misplacement of reusable	
WASTE TRANSPORTATION						
Ensure internal safe movement of covered carts/bins for waste	HMT		HCWMO	Quarterly	Number of carts as recommended	
Ensure availability of staff specifically designated for waste movement	HMT		HCWMO	Monthly	Number of positions filled on the establishment form	
Ensure availability and use of appropriate tools, protective wear and safety equipment	HMT		HCWMO	Quarterly	Number of Healthcare workers having and using PPE	
Provide covered trucks for movement of waste to distant disposal site where necessary	MHCDGEC/ LGA		VPO-Envt	Every six months	Number of working trucks available as recommended	
Follow defined routes of waste (loaded carts) movement	HMT		HCWMO	Daily	Number of carts using the designated route	
Ensure availability of washing and disinfecting material for staff	HCWMO		HMT	Daily	Quantity of disinfectant available in recommended places	
TREATMENT AND DISPOSAL						
Ensure availability and use of appropriate tools and PPE for personnel at disposal sites	HCWMO		HCWMO	Quarterly	Number of people having and using PPE	

Ensure appropriate method of treatment is used for each type of waste	HCWMO		NEMC and VPO-Environment	Monthly	Monthly Number of complaints against poor waste treatment and disposal - Number, type and list of functional HCWM infrastructure	
Install incinerators with air pollution treatment facilities	MHCDGEC		NEMC and VPO Envt	Monthly	Number of HCF with installed incinerators that meet Air quality	
DISPOSAL SITE LOCATION						
All year-round accessibility to disposal site	LGA		NEMC and VPO Envt	Biannually	Number of cases of failure to access site	
Location of disposal site to be: - Far from habited areas - On a leeward side - Far from reach of animals - Low water table sites	LGA		NEMC and VPO Envt	As necessary during disposal facility siting	Number of complaints from neighboring residents Ground water quality	
GENERAL COMPLIANCE						
Use of appropriate technology	MoH		NEMC and VPO Envt	Quarterly	Number of complaints on poor waste management	
General health and safety of workers, employees and public	MoH		NEMC and VPO Envt	Quarterly	Number of complaints against health and safety	
Control Nuisance (air pollution, dust, smell and aesthetics	MoH/ LGA		NEMC and VPO MoEnvt	Quarterly	Number of complaints against nuisance	
Set measures that prevent water pollution	MoH / LGA		NEMC and VPOEnvt Ministry responsible for Water Resources	Quarterly	Water quality	

ANNEX V. DISBURSEMENT LINKED INDICATORS, DISBURSEMENT ARRANGEMENTS AND VERIFICATION PROTOCOLS *(Extracted from the Program PAD)*

Disbursement Linked Indicators Matrix				
DLI 1	Improved annual delivery and quality of maternal and child health services by the LGAs			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Outcome	Yes	Text	81,000,000.00	0.00
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	60%			
July 1, 22 to June 30, 23	Increase in the annual average LGA score		17,000,000.00	% scores and allocation: ≤60%=0; 61-70%=50%; 71-80%=60%; 81-90%=80%; ≥91%=100%
July 1, 23 to June 30, 24	Increase in the annual average LGA score		16,000,000.00	% scores and allocation: ≤60%=0; 61-70%=50%; 71-80%=60%; 81-90%=80%; ≥91%=100%
July 1, 24 to June 30, 25	Increase in the annual average LGA score		16,000,000.00	% scores and allocation: ≤60%=0; 61-70%=50%; 71-80%=60%; 81-90%=80%; ≥91%=100%
July 1, 25 to June 30, 26	Increase in the annual average LGA score		16,000,000.00	% scores and allocation: ≤60%=0; 61-70%=50%; 71-80%=60%; 81-90%=80%; ≥91%=100%

July 1, 26 to June 30, 27	Increase in the annual average LGA score	16,000,000.00	% scores and allocation: ≤60%=0; 61-70%=50%; 71-80%=60%; 81-90%=80%; ≥91%=100%

DLI 2	Improved annual performance of national and regional entities in supporting the LGAs to deliver PHC services			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Intermediate Outcome	Yes	Text	9,000,000.00	
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	60%			
July 1, 22 to June 30, 23	Increase in the average annual national and regional score		1,800,000.00	% scores and allocation: ≤60%=0; 61-70%=50%; 71-80%=60%; 81-90%=80%; ≥91%=100%
July 1, 23 to June 30, 24	Increase in the average annual national and regional score		1,800,000.00	% scores and allocation: ≤60%=0; 61-70%=50%; 71-80%=60%; 81-90%=80%; ≥91%=100%
July 1, 24 to June 30, 25	Increase in the average annual national and regional score		1,800,000.00	% scores and allocation: ≤60%=0; 61-70%=50%; 71-80%=60%; 81-90%=80%; ≥91%=100%
July 1, 25 to June 30, 26	Increase in the average annual national and regional score		1,800,000.00	% scores and allocation: ≤60%=0; 61-70%=50%; 71-80%=60%; 81-90%=80%; ≥91%=100%
July 1, 26 to June 30, 27	Increase in the average annual national and regional score		1,800,000.00	% scores and allocation: ≤60%=0; 61-70%=50%; 71-80%=60%; 81-90%=80%; ≥91%=100%

DLI 3	Increased capacity for training health workers			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Intermediate Outcome	Yes	Text	11,000,000.00	
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	No plans to for capacity strengthening of selected training institutions, mentorship/coaching, or training			
July 1, 22 to June 30, 23	The MoH has developed and approved the (i) the plans to strengthen capacity of selected training institutions to conduct competence-based training; (ii) a strategy and plan for mentorship, coaching and attachment of HRH; and (iii) a training plan for priority cadres.		1,000,000.00	For each achievement, (i) US$0.5m; (ii) US$0.25m; (iii) US$0.25m
July 1, 23 to June 30, 24	The training institutions have reached key milestones in the implementation of individual plans to strengthen capacity to conduct competence-based training.		3,000,000.00	See the DLI procedure
July 1, 24 to June 30, 25	The training institutions have reached key milestones in the implementation of individual plans to strengthen capacity to conduct competence-based training.		4,000,000.00	See the DLI procedure
July 1, 25 to June 30, 26	The training institutions have reached key milestones in the implementation of individual plans to strengthen capacity to conduct competence-based training.		3,000,000.00	See the DLI procedure

July 1, 26 to June 30, 27	--		0.00	--

DLI 3.1	Number of HRH who have received mentorship, coaching and attachment			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	Yes	Number	8,000,000.00	
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	0.00			
July 1, 22 to June 30, 23	2,000.00		2,000,000.00	US$1,000 for each health worker who begin to be mentored, coached, and attached in each FY.
July 1, 23 to June 30, 24	4,000.00		4,000,000.00	US$1,000 for each health worker who begin to be mentored, coached, and attached in each FY.
July 1, 24 to June 30, 25	2,000.00		2,000,000.00	US$1,000 for each health worker who begin to be mentored, coached, and attached in each FY.
July 1, 25 to June 30, 26	0.00		0.00	--
July 1, 26 to June 30, 27	0.00		0.00	--

DLI 3.2	Number of students sponsored for priority courses with a focus on MCH			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	Yes	Number	6,000,000.00	
Period	**Value**		**Allocated Amount (USD)**	**Formula**

Baseline	0.00		
July 1, 22 to June 30, 23	0.00	0.00	--
July 1, 23 to June 30, 24	250.00	2,500,000.00	US$10,000 for each student sponsored for the priority courses
July 1, 24 to June 30, 25	350.00	3,500,000.00	US$10,000 for each student sponsored for the priority courses
July 1, 25 to June 30, 26	0.00	0.00	--
July 1, 26 to June 30, 27	0.00	0.00	--

DLI 4	Increased availability of skilled staff at the PHC facilities			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Intermediate Outcome	Yes	Text	6,000,000.00	
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	No recruitment/deployment plan			
July 1, 22 to June 30, 23	(a) PORALG has developed and approved a recruitment and deployment plan of staff on contract; and (b) 145 health staff recruited and posted to the PHC facilities		2,530,000.00	(a) approved rec./dep. plan=US$0.5m; (b) US$14k for each staff recruited and posted
July 1, 23 to June 30, 24	248 health staff recruited and posted to the PHC facilities		3,470,000.00	US$14k for for each staff recruited and posted
July 1, 24 to June 30, 25	--		0.00	--
July 1, 25 to June 30, 26	--		0.00	--

July 1, 26 to June 30, 27	--		0.00	--

DLI 5	Number of regions with established referral services			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Outcome	Yes	Text	5,000,000.00	
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	No strategy for management of referral and emergencies			
July 1, 22 to June 30, 23	The MoH and PORALG have prepared and approved strategy for management of referral and emergencies customized at the regional level		100,000.00	Upon confirmation of approved strategy
July 1, 23 to June 30, 24	5 regions with operational systems for management of referrals and emergencies		2,450,000.00	US$0.49M for each region with established systems for management of referrals and emergencies
July 1, 24 to June 30, 25	5 additional regions with operational systems for management of referrals and emergencies		2,450,000.00	US$0.49M for each region with established systems for management of referrals and emergencies
July 1, 25 to June 30, 26	--		0.00	--
July 1, 26 to June 30, 27	--		0.00	--

DLI 5.1	Increased number of referral cases managed through the established referral and emergency systems by the regions			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	Yes	Text	5,000,000.00	
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	0.00			
July 1, 22 to June 30, 23	--		0.00	--
July 1, 23 to June 30, 24	2,500 referral cases managed		500,000.00	US$200 per case managed through the established referral and emergency systems.
July 1, 24 to June 30, 25	7,500 referral cases managed		1,500,000.00	US$200 per case managed through the established referral and emergency systems.
July 1, 25 to June 30, 26	7,500 referral cases managed		1,500,000.00	US$200 per case managed through the established referral and emergency systems.
July 1, 26 to June 30, 27	7,500 referral cases managed		1,500,000.00	US$200 per case managed through the established referral and emergency systems.

DLI 6	Number of selected RRHs with approved capacity building and refurbishment plans			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	Yes	Text	1,000,000.00	
Period	**Value**		**Allocated Amount (USD)**	**Formula**

Baseline	0.00		
July 1, 22 to June 30, 23	4 RRHs with approved capacity building and refurbishment plans	400,000.00	US$0.1M for each RRH with an approved capacity building and refurbishment plan
July 1, 23 to June 30, 24	6 RRHs with approved capacity building and refurbishment plans	600,000.00	US$0.1M for each RRH with an approved capacity building and refurbishment plan
July 1, 24 to June 30, 25	--	0.00	--
July 1, 25 to June 30, 26	--	0.00	--
July 1, 26 to June 30, 27	--	0.00	--

DLI 6.1	RRHs have reached key milestones in the implementation of individual refurbishment plans			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Process	Yes	Text	18,000,000.00	
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	No milestones reached			
July 1, 22 to June 30, 23	Reaching key milestones		3,000,000.00	See the DLI procedure
July 1, 23 to June 30, 24	Reaching key milestones		6,000,000.00	See the DLI procedure
July 1, 24 to June 30, 25	Reaching key milestones		6,000,000.00	See the DLI procedure
July 1, 25 to June 30, 26	Reaching key milestones		3,000,000.00	See the DLI procedure
July 1, 26 to June 30, 27	--		0.00	--

DLI 6.2	Increased number of RRHs that have completed implementation of the approved capacity building plans			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	Yes	Text	6,000,000.00	
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	No capacity building plan that have been agreed upon			
July 1, 22 to June 30, 23	--		0.00	--
July 1, 23 to June 30, 24	Completion of capacity building plan		2,500,000.00	US$0.4M for each RRH upon completion of implementation of the capacity building plan
July 1, 24 to June 30, 25	Completion of capacity building plan		3,000,000.00	US$0.4M for each RRH upon completion of implementation of the capacity building plan
July 1, 25 to June 30, 26	Completion of capacity building plan		500,000.00	US$0.4M for each RRH upon completion of implementation of the capacity building plan
July 1, 26 to June 30, 27	--		0.00	--

DLI 6.3	Increased number of emergency and referral cases managed by the RRHs			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	Yes	Text	3,000,000.00	
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	0.00			

July 1, 22 to June 30, 23	--	0.00	--
July 1, 23 to June 30, 24	1,000 Emergency and referral cases managed	200,000.00	US$200 per case managed by the RRH.
July 1, 24 to June 30, 25	4,000 Emergency and referral cases managed	800,000.00	US$200 per case managed by the RRH.
July 1, 25 to June 30, 26	6,000 Emergency and referral cases managed	1,200,000.00	US$200 per case managed by the RRH.
July 1, 26 to June 30, 27	4,000 Emergency and referral cases managed	800,000.00	US$200 per case managed by the RRH.

DLI 7	LGAs that have refurbished selected PHC facilities as per the approved plans			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Process	Yes	Text	22,000,000.00	
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	No assessment plan or report			
July 1, 22 to June 30, 23	PORALG has prepared and approved the assessment report and plan to address the performance gaps including human resources, equipment and refurbishment needs for selected PHC facilities		1,000,000.00	Approved assessment report/plan confirmed=US$1M
July 1, 23 to June 30, 24	The PHC facilities have reached key milestones in the implementation of individual refurbishment plans		5,000,000.00	See the procedure section

July 1, 24 to June 30, 25	The PHC facilities have reached key milestones in the implementation of individual refurbishment plans	9,000,000.00	See the procedure section
July 1, 25 to June 30, 26	The PHC facilities have reached key milestones in the implementation of individual refurbishment plans	7,000,000.00	See the procedure section
July 1, 26 to June 30, 27	--	0.00	--

DLI 7.1	PORALG has procured the medical equipment and deployed them to the PHC facilities as per the procurement plan			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	Yes	Text	8,000,000.00	
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	No procurement plan			
July 1, 22 to June 30, 23	PORALG has prepared and approved the procurement plan to equip the PHC facilities		1,000,000.00	US$1M upon confirmation of the approved procurement plan for equipment
July 1, 23 to June 30, 24	PORALG has signed the procurement contracts		7,000,000.00	US$7M upon confirmation of the signed contracts for procurement of equipment
July 1, 24 to June 30, 25	--		0.00	--
July 1, 25 to June 30, 26	--		0.00	--
July 1, 26 to June 30, 27	--		0.00	--

DLI 7.2	Increased number of PHC facilities (dispensaries, health centers and district hospitals) that are functional and meet the requisite standards			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	Yes	Text	5,000,000.00	
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	Activity not yet started			
July 1, 22 to June 30, 23	--		0.00	--
July 1, 23 to June 30, 24	X% meeting standards for year 2		1,000,000.00	US$X per PHC facility confirmed functional and meeting the requisite standards. The estimates per type of facility is in X
July 1, 24 to June 30, 25	Y% meeting standards for year 2		2,000,000.00	US$X per PHC facility confirmed functional and meeting the requisite standards. The estimates per type of facility is in X
July 1, 25 to June 30, 26	Z% meeting standards for year 2		2,000,000.00	US$X per PHC facility confirmed functional and meeting the requisite standards. The estimates per type of facility is in X
July 1, 26 to June 30, 27	--		0.00	--

DLI 8	Improved management and accountability			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Intermediate Outcome	Yes	Text	11,000,000.00	
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	No annual plan that has been agreed upon			
July 1, 22 to June 30, 23	Implementation of annual plan of activities		2,000,000.00	See the DLI procedure
July 1, 23 to June 30, 24	Implementation of annual plan of activities		2,000,000.00	See the DLI procedure
July 1, 24 to June 30, 25	Implementation of annual plan of activities		2,500,000.00	See the DLI procedure
July 1, 25 to June 30, 26	Implementation of annual plan of activities		2,500,000.00	See the DLI procedure
July 1, 26 to June 30, 27	Implementation of annual plan of activities		2,000,000.00	See the DLI procedure

Verification Protocol Table: Disbursement Linked Indicators	
DLI 1	Improved annual delivery and quality of maternal and child health services by the LGAs
Description	represents annual performance of the LGAs in the delivery of MCH services. The LGA performance is assessed annually based on an average LGA score from a set of 10 results/indicators. Disbursements for the DLI are made annually on a scalable basis. The calculation for Year 1 (2022/23) disbursement is based on the average LGA score for the year 2021/22.
Data source/ Agency	LGAs
Verification Entity	IAG
Procedure	(a) Average annual score ≤60 percent: no disbursement; (b) 61 – 70 percent score: 50 percent disbursement of annual allocation; (c) 71- 80 percent score: 60 percent disbursement of annual allocation; (d) 81 – 90 percent score: 80 percent disbursement of annual allocation; and (e) ≥91 percent score: 100 percent disbursement of annual allocation. From year 2 onwards, in addition to disbursing against achievement in a given year, if a higher percentage is achieved than the previous FYs, the corresponding additional amount out of the undisbursed balance from previous FYs can be disbursed, not to exceed the sum of the undisbursed amounts from previous FYs.
DLI 2	Improved annual performance of national and regional entities in supporting the LGAs to deliver PHC services
Description	This DLI represents annual performance of the national entities (MoH and PORALG) and RHMTs in supporting LGAs in the delivery of MCH services. The performance of the entities is measured annually based an average score from a set of 4 indicators below. Disbursements for the DLI are made annually on a scalable basis. The calculation for Year 1 (2022/23) disbursement is based on the average score for the year 2021/22.
Data source/ Agency	MoH and PORALG
Verification Entity	IAG
Procedure	(a) Average annual score ≤60 percent: no disbursement; (b) 61 – 70 percent score: 50 percent disbursement of annual allocation; (c) 71- 80 percent score: 60 percent disbursement of annual allocation; (d) 81 – 90 percent score: 80 percent disbursement of annual allocation; and (e) ≥91 percent score: 100 percent disbursement of annual allocation. From year 2 onwards, in addition to disbursing against achievement in a given year, if a higher percentage is achieved than the previous FYs, the corresponding additional amount out of the undisbursed balance from previous FYs can be disbursed, not to exceed the sum of the undisbursed amounts from previous FYs.

DLI 3	Increased capacity for training health workers
Description	The disbursements are made against (a) approved designs (by relevant government authority) and NEMC approval of the Environmental Impact Assessment (EIA); (b) approved certificate of progress of the works issued by a qualified professional; and (c) approved completion report for implementation of capacity building activities. For completion of implementation of capacity building activities, the result is achieved upon verification of completion of implementation of the activities by the individual training institutions as stated in the respective plans. The capacity building activities may include (a) placement of the tutors, (b) completion of curriculum review process, (c) acquisition of teaching materials, books, and equipment; and (d) establishment of skills laboratories.
Data source/ Agency	
Verification Entity	IAG
Procedure	For DLR 3.1, i) US$0.5 M for approved plan to strengthen capacity of training institutions; ii) US$0.25 M for approved strategy and plan for mentorship, coaching and attachment; and iii) US$0.25 M for approved training plan for priority courses. Cumulative disbursements not to exceed US$1 M. For DLR 3.2-3.5, disbursements against each institution for: (a) approved designs and NEMC approval of the EIA - US$0.2 M; (b) certificate of 30 percent of the works - US$0.3 M; (c) certificate of 70 percent of the works - US$0.4 M; (d) certificate of 100 percent of the works - US$0.3 M; (e) completion of implementation of capacity building activities – US$0.2 M. Plan to refurbish 15 training institutions in total. Cumulative disbursements not to exceed US$15 M.

DLI 3.1	Number of HRH who have received mentorship, coaching and attachment
Description	US$1,000 for each health worker who begin to be mentored, coached, and attached in each FY. Cumulative disbursements not to exceed US$4 M.
Data source/ Agency	
Verification Entity	IAG
Procedure	

DLI 3.2	Number of students sponsored for priority courses with a focus on MCH
Description	US$1,000 for each students admitted and sponsored by MoH for priority PHC courses with a focus on MCH. Cumulative disbursement not to exceed US$4 M.
Data source/ Agency	MoH Human Resources Department

Verification Entity	IAG
Procedure	
DLI 4	Increased availability of skilled staff at the PHC facilities
Description	The approved recruitment and deployment plan prepared by PORALG is to include the type of cadres, their numbers and LGAs where the staff are to be deployed. Disbursement under DLRs related to staff recruitment is made against the verified annual report prepared by PORALG on recruitment and deployment of the staff to the PHC facilities.
Data source/ Agency	PORALG
Verification Entity	IAG
Procedure	US$0.5 million upon confirmation of the approved recruitment and deployment plan. US$14,000 for each staff recruited and posted to the PHC facilities. Cumulative disbursement for this will not to exceed US$8 million.
DLI 5	Number of regions with established referral services
Description	An established referrals system is confirmed when the region has in place (a) transport arrangements/ambulances; (b) trained crews; (c) operational electronic dispatch system; (d) designated staff to coordinate referrals in the health facilities; and (e) protocol for management of referrals (10 regions).
Data source/ Agency	MoH/ RHMTs
Verification Entity	IAG
Procedure	
DLI 5.1	Increased number of referral cases managed through the established referral and emergency systems by the regions
Description	
Data source/ Agency	
Verification Entity	IAG
Procedure	US$200 per case managed through the established referral and emergency systems. Cumulative disbursements not to exceed US$3.5 million.

DLI 6	Number of selected RRHs with approved capacity building and refurbishment plans
Description	The RRH capacity building plans are to include acquisition of medical equipment, scaling up use of the electronic medical records in the facility, institutionalization of clinical audits, and establishment of virtual referral services using telemedicine.
Data source/ Agency	
Verification Entity	IAG
Procedure	

DLI 6.1	RRHs have reached key milestones in the implementation of individual refurbishment plans
Description	For refurbishments, the disbursements are made against (a) approved designs (by relevant government authority) and NEMC approval of the EIA and (b) approved certificates of progress of the works issued by a qualified professional as per government policy. (10 RRHs)
Data source/ Agency	
Verification Entity	
Procedure	Disbursements against each RRH for: (a) approved designs and NEMC approval of the EIA - US$0.1 M; (b) certification of 30 percent completion of the works - US$0.5 M; (c) certification of 70 percent completion of the works - US$0.6 M; (d) certification of 100 percent completion of the works - US$0.3 M; Cumulative disbursements not to exceed US$15 M.

DLI 6.2	Increased number of RRHs that have completed implementation of the approved capacity building plans
Description	For completion of implementation of capacity building activities, the result is achieved upon verification of completion of implementation of the activities by the individual RRHs as stated in the respective approved plans.
Data source/ Agency	
Verification Entity	IAG
Procedure	The onetime disbursement is made upon submission of the completion report for the individual RRHs. The actual disbursement amount is based on the percentage of activities executed. Disbursed amount not to exceed US$0.4 M per RRH.

DLI 6.3	Increased number of emergency and referral cases managed by the RRHs
Description	The emergency and referral cases managed by the RRHs is determined from cases referred through the dispatch center. US$200 per case managed by the RRH. Cumulative disbursements not to exceed US$1.4 million.
Data source/ Agency	
Verification Entity	IAG
Procedure	
DLI 7	LGAs that have refurbished selected PHC facilities as per the approved plans
Description	For refurbishments, the disbursements are made against (a) approved designs (by relevant government authority) and NEMC approval of the EIA and (b) approved certificates of progress of the works issued by a qualified professional as per government policy.
Data source/ Agency	
Verification Entity	IAG
Procedure	Disbursements against each PHC facility for: (a) approved designs and NEMC approval of the EIA – 30 percent of the estimated cost per type of PHC facility; (b) certification of 50 percent completion of the works – 40 percent of the estimated cost; and (c) certification of 80 percent completion of the works – 30 percent of the estimated cost; The estimates per type of facility are as follows: US$650,000 per district hospital, US$220,000 per health center, and US$110,000 per dispensary. In total, 10 district hospitals, 35 health centers and 60 dispensaries are to be refurbished. Cumulative disbursements not to exceed US$22 million.
DLI 7.1	PORALG has procured the medical equipment and deployed them to the PHC facilities as per the procurement plan
Description	For procurement of medical equipment, the disbursements are made against confirmation of the (a) approved procurement plan and (b) signed contracts for the procurement of medical equipment as per the procurement plan.
Data source/ Agency	
Verification Entity	IAG
Procedure	

DLI 7.2	Increased number of PHC facilities (dispensaries, health centers and district hospitals) that are functional and meet the requisite standards
Description	Increased number of selected PHC facilities (dispensaries, health centers and district hospitals) that are functional and meet the requisite standards. Each year PORALG from the original list of selected PHC facilities will report on the facilities that became functional.
Data source/ Agency	
Verification Entity	IAG
Procedure	a. US$20 K for each dispensary established as functional and meeting the requisite standards (perform signal functions for basic emergency obstetric and newborn care - administration of parenteral antibiotics, administration of parenteral anticonvulsants, administration of parenteral uterotonic agents, removal of retained products using MVA, manual removal of placenta and resuscitation of the newborn using the ambu bag). Plan to make 100 dispensaries functional over the operation's duration b. US$40 K for each health center established as functional and meeting the requisite standards (perform signal functions for comprehensive emergency obstetric and newborn care – safe blood transfusion, cesarean sections, KMC and oxygen availability) Plan to get 50 health centers functional over the operation's duration c. US$60 K for each district hospital established as functional and meeting the requisite standards. Besides comprehensive obstetric care, district hospitals are to provide the following newborn care services to be functional (i) thermal care including KMC for all stable neonates <2000gms; (ii) assisted feeding and IV fluids, (iii) safe administration of oxygen, (iv) detection and management of neonatal sepsis with injection antibiotics, (v) detection and management of neonatal jaundice with phototherapy, (vi) detection and management of neonatal encephalopathy, and (vii) detection and referral/management of congenital abnormalities. Plan to get 15 district hospitals functional over the operation's duration. Cumulative total not to exceed US$5 M.
DLI 8	Improved management and accountability
Description	The plans will be reviewed and agreed each year between the government and IDA. This DLI represents the percentage of activities (weighted against the budget) completed in the agreed plan in the previous fiscal year. Disbursement for this DLI will be made annually on a scalable basis.
Data source/ Agency	
Verification Entity	IAG

Procedure	For PORALG: Percentage of completed activities in the plan approved in the previous fiscal year: MCH coordination, Program management, capacity building, social accountability, and environmental and social management. The total does not exceed US$4 million with annual targets of 100% for $0.8 million). For MOH: Percentage of completed activities in the plan approved in the previous fiscal year: MCH coordination, Program management, verification, audit, capacity building, star rating assessment, and environmental and social management. The total does not exceed US$6 million with annual of targets 100% for $1.2 million.