Program Information Documents (PID)

Appraisal Stage | Date Prepared/Updated: 30-Sep-2022 | Report No:

BASIC INFORMATION

A. Basic Program Data

Country	Project ID	Program Name	Parent Project ID (if any)
Tanzania	P170435	Tanzania Maternal and Child Health Investment Program	
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
EASTERN AND SOUTHERN AFRICA	19-Sep-2022	30-Nov-2022	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Program-for-Results Financing	United Republic of Tanzania	Ministry of Health	

Proposed Program Development Objective(s)

To scale-up provision and improve quality of essential health care services with a focus on Maternal and Child Health.

COST & FINANCING

SUMMARY (USD Millions)

Government program Cost	2,347.00
Total Operation Cost	225.00
Total Program Cost	205.00
IPF Component	20.00
Total Financing	225.00
Financing Gap	0.00

FINANCING (USD Millions)

Total World Bank Group Financing	200.00
World Bank Lending	200.00
Total Non-World Bank Group and Non-Client Government Financing	25.00

Trust Funds	25.00

Decision

The review did authorize the team to appraise and negotiate

B. Introduction and Context

Country Context

1. **The United Republic of Tanzania is a union between Tanzania Mainland and Zanzibar**. The population in 2020 was estimated at 57.6 million inclusive of 1.67 million for Zanzibar.[1] 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. Tanzania is experiencing rapid urbanization with about 34.5 percent of the population (46 percent for Zanzibar) designated as urban in 2020 compared with 19 percent in 1988. While the national poverty rate in Tanzania has declined from 34.4 to 26.4 percent between 2007 and 2018, a large proportion of the population remains vulnerable and risks falling back into poverty. In 2018 almost half of the population was living below the international poverty line of US$1.9 per day.

2. **Prior to the COVID-19 pandemic, Tanzania experienced relatively stable economic growth.**[2] Between 2013 and 2018, Tanzania's gross domestic product (GDP) grew at an average annual rate of 6.5 percent (7 percent in Zanzibar), and the country graduated into lower-middle income status in July 2020. The COVID-19 pandemic inflicted a shock on the Tanzanian economy and reduced the GDP growth rate to 2.5 percent in 2020, in contrast with 6.9 percent in 2019. The Human Capital Index (HCI) for Tanzania in 2020 was estimated at 0.39, which means that children born today will be 39 percent as productive as they could have been as adults had they enjoyed complete education and full health. While this figure is on par with the Sub-Saharan Africa average, it is significantly below the 0.48 average of lower-middle income countries, placing Tanzania among the bottom 35 countries globally. Tanzania's (mainland) vision is to improve livelihoods of the people and develop a strong and competitive economy.[3] This vision is outlined in the National Development Plan (2016/17 – 2020/21). Like the mainland, Zanzibar's Development Vision 2050 (ZDV50)[4] is centered on human development and economic growth and acknowledges the ramifications of the high population growth rate on economic development and the need to resolve the persistent quality gaps in the delivery of health services.

Sectoral and Institutional Context

3. **Over the last two decades, Tanzania has significantly reduced the disease burden and improved population health outcomes**. The disease burden dropped from 88,225 to 41,047 disability adjusted life years (DALYs) per 100,000 population between 2000 and 2019. Over the same period, life expectancy increased from

[1] Population Projections of the Tanzania National Bureau of Statistics 2018
[2] Tanzania Economic Update, Jan 2022
[3] Vision 2025 (Mainland Tanzania)
[4] Zanzibar Development Vision 2050

51 to 65 years while under-five mortality and infant mortality dropped from 148 deaths and 98 deaths per 1,000 live births to 67 deaths and 43 deaths per 1,000 live births, respectively. The improvements are attributed to the control of major communicable diseases including vaccine preventable diseases, diarrheal diseases, malaria, and HIV/AIDS. Compared with mainland Tanzania, Zanzibar has low prevalence of communicable diseases of global public health significance. Despite the progress Tanzania has made, the disease burden remains high. Communicable diseases remain the major cause of morbidity and mortality. Neonatal disorders are the third key driver of the disease burden with newborn mortality rate of 27 deaths per 1000 live births. Maternal mortality ratio has stagnated at about 530 deaths per 100,000 live births in mainland Tanzania. The high total fertility rate (TFR, 5.2 per woman) together with early marriage and childbearing among adolescent girls are among the factors that partly drive the high maternal mortality. Moreover, stunting is persistently high affecting 34 percent of children under five years of age. In Zanzibar, neonatal mortality and acute malnutrition remain high. The burden of noncommunicable diseases (NCDs) is rapidly increasing and Tanzania is experiencing a double burden of disease from communicable diseases and NCDs.

4. **In general, physical access to health services has significantly improved in Tanzania and most people live within a 10 km radius from a clinic**. Tanzania has also registered significant increase in utilization and coverage of several essential health services. However, low quality of care remains a major impediment to improving delivery of health services. Coupled with the fact that most health facilities operate below their designated standards for a variety of reasons including gaps with staffing, medical equipment, supplies and infrastructure, there has been limited less success with provision of emergency obstetric care, newborn care, family planning, emergency and referral services and nutrition services. Coverage of the six signal functions for newborn care is limited; in 2015 only 47 percent of mothers reported at least two of these six signal functions were performed during childbirth.[5] The specific guidelines, while available in most instances, are not routinely applied. Furthermore, many of the quality improvement initiatives are implemented on a limited scale.

5. **The health sector in Tanzania faces several health systems challenges.** Shortages and inequitable distribution of the health workforce are major impediments to health service delivery. There is an overall staff shortage of 52 percent with the PHC facilities most adversely affected. Although, considerable effort was made to expand health infrastructure, the expansion was not accompanied by staff placement and provision of matching inputs including equipment, utilities, and operational costs. As a result, many health facilities operate well below their designated standards. The current referral system is weak and plagued by coordination challenges. Besides weaknesses with operations of the ambulance services, many of the referral hospitals are crowded with primary patients and are unable to manage emergencies and treatment of critically ill patients rendering hospitals unable to provide the essential critical care services as part of the continuum of care. Finally, the health sector in Tanzania is underfunded. Total per capita health spending is estimated at US$35 for mainland Tanzania (US$30 in Zanzibar).[6] The share of the government budget for health has been declining for both mainland Tanzania and Zanzibar.

6. **The government health programs are outlined in the recently launched sector strategic plans.**[7] These plans are anchored on the existing national development frameworks and health policy[8] and build on the previous

[5] The six signal functions include cord examination, temperature measurement, counseling on danger signs, counseling on breast feeding, observing breast feeding, and weighing the baby.
[6] McIntyre D, Meheus F, Rottingen J A. 2017. "What Level of Domestic Government Health Expenditure Should We Aspire to for Universal Health Coverage?" Health Economics Policy and Law 12 (2): 12–37.
[7] Health Sector Strategic Plan V (2021 -2026) for mainland Tanzania, and Health Sector Strategic Plan IV (2020 – 2025) for Zanzibar
[8] Mainland National Health Policy 2007 and Zanzibar Health Policy 2011

plans.[9] These plans aim to improve access to essential health services as part of universal health coverage and give priority to strengthening health systems functions to address the major causes of disease burden. Mainland Tanzania prepared a National Road Map Strategic Plan to Improve Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH, One Plan III 2020 - 2025). For mainland Tanzania, the plans aim to address the high maternal and neonatal mortality, adolescent health services, inequitable access and coverage of services, low quality of care, functionality of the health facilities, challenges with the health workforce, and increasing health financing. The plan also intends to address emerging priorities – increasing burden of non-communicable diseases, growing urbanization, climate change and emerging diseases, and to take advantage of the opportunities brought about technology.

PforR Program Scope

7. **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.

8. **The operation will cover both mainland Tanzania and Zanzibar**. The operation will use the PforR instrument for mainland Tanzania and an IPF for Zanzibar. The PforR Program in mainland Tanzania 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 under the following five Key Result Areas: (i) maternal and child health services; (ii) human resources for health; (iii) emergency and referral services; (iv) health facility performance and functionality; and (v) management and accountability functions. The operation in Zanzibar using the IPF instrument will support two components (a) scale up provision of maternal and child health (MCH) services and (b) enhance institutional capacity to manage project supported activities. 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 MCH interventions.

9. **Health is a nonunion matter, and mainland Tanzania and Zanzibar will each establish separate implementation arrangements**. While some activities are to be implemented on a national scale, others will be focused to specific regions. The operation will contribute towards scaling up priority MCH-N interventions and addressing selected health systems bottlenecks relevant for the delivery of MCH services. The operation will prioritize obstetric and newborn care, family planning and adolescent health, emergency and referral services, quality of care, strengthening capacity for human resources for health management, ensuring functionality of the existing health infrastructure, scaling up use of electronic systems in the delivery of health services, and strengthening capacity of the community platform to deliver health services. The operation's implementation will be mainstreamed, and part of its funding channeled through the Health Basket Fund (HBF) arrangement, which has worked well for the previous operations. The operation draws on lessons from the previous project (Strengthening Primary Health Care for Results Program, P152736), other programs in the country as well as global experiences.

[9] Tanzania mainland - HSSP IV (HSSP IV 2015 - 2020), Zanzibar – HSSP III 2013/14-2018/19.

10. **A set of eight disbursement-linked indicators (DLIs) will form the basis for disbursements for the Program in mainland Tanzania**. The DLIs correspond to the key results areas 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 basis. (Figure 1)

Figure 1. Summary of activities by results area.

Key Results Area	Disbursement Linked Indicators
Maternal and child health services	DLI 1. Performance of the LGAs as measured by average LGA scorecard
	DLI 2. Improved annual performance of central and regional entities in supporting the LGAs to deliver PHC services
Human resources for health	DLI 3. Increased capacity for training health workers
	DLI 3.1. Number of HRH who have received mentorship, coaching and attachment
	DLI 3.2. Number of students sponsored for priority courses with a focus on MCH
	DLI 4. Increased availability of skilled staff at the PHC facilities
Emergency and referral services.	DLI 5. Number of regions with established referral and emergency systems
	5.1. Number of referral cases managed by the regions through the established referral and emergency systems
	DLI 6. RRHs reaching key milestones in the implementation of individual refurbishment and capacity building plans
	DLI 6.1. Number of emergency and referral cases managed by the RRHs
Health facility performance and functionality	DLI 7. Selected PHC facilities that have been refurbished as per the approved plans
	DLI 7.1. Increased number of PHC facilities that are equipped, functional and perform the requisite signal functions for emergency obstetric and newborn care
Management and accountability	DLI 8. Percentage of planned annual capacity building, management and accountability activities implemented

C. Proposed Program Development Objective(s)

Program Development Objective(s)

11. To scale-up provision and improve quality of essential health care services with a focus on Maternal and Child Health.

12. The PDO level results indicators include:

a) Percentage of dispensaries with at least two qualified/skilled health providers (nurse/midwife and clinicians)
b) Percentage of PHC facilities achieved 3 stars and above
c) Percentage of newborns receiving postnatal care within 48 hours after delivery
d) Percentage of pregnant women attending first ANC visit in the first trimester
e) Percentage of patients referred (through the dispatch center – new system) that are managed at receiving health facility
f) Percentage of funds received through DHFF by the health facilities that is utilized in the financial yea

D. Environmental and Social Effects

13. **Environmental and social risks are considered Substantial.** As noted in the E&S section above, the main E&S risks are related to health and safety risks associated with infrastructure improvement, likely increased generation of HCW and current weak Environmental Management Capacity of the Borrower including weak inter-institutional and coordination among various agencies to undertake implementation of Environmental and Social Managemen Plans, and likely cumulative E&S risks & impacts given the country-wide coverage of the program. The World Bank will provide close support in implementing and monitoring E&S aspects of the operation as needed, training of E&S Staff on E&S Risk Management, implementing HCWM requirements for each facility to address identified gaps.

Legal Operational Policies

	Triggered?
Projects on International Waterways OP 7.50	No
Projects in Disputed Areas OP 7.60	No

Summary of Assessment of Environmental and Social Risks and Impacts (With IPF Component for PforR)

E. Financing

14. **The total cost of the program is estimated at US$2,347 billion over the five years (2022/23 – 2026/27), of which US$205 million (6 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 GFF Essential Health Services grant. 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.

Program Financing

Source	Amount (US$ millions)	Percent of Total
Government budget	1,862	79%
International Development Association (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%**

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