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Report No: ICR 5729

IMPLEMENTATION COMPLETION AND RESULTS REPORT
(IDA-56430; TF-A9831; TF-A1567; TF-A0261; TF-A0270)

ON A CREDIT
IN THE AMOUNT OF SDR 145 MILLION
(US$200 MILLION EQUIVALENT)

AND A GRANT FROM ACHIEVING NUTRITION IMPACT AT SCALE MULTI-DONOR TRUST FUND
IN THE AMOUNT OF US$20 MILLION

AND GRANTS FROM UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT
IN THE AMOUNT OF US$14.5 MILLION

AND A GRANT FROM MULTI-DONOR TRUST FUND FOR THE GLOBAL FINANCING FACILITY IN SUPPORT OF EVERY WOMAN EVERY CHILD
IN THE AMOUNT OF US$40 MILLION

TO THE

UNITED REPUBLIC OF TANZANIA

FOR THE

STRENGTHENING PRIMARY HEALTH CARE FOR RESULTS
PROGRAM-FOR-RESULTS

March 29, 2022

Health, Nutrition and Population Global Practice
Eastern and Southern Africa Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective March 20, 2022)

Currency Unit	=	Tanzania Shilling (TZS)
TZS 2,317.01	=	US$1
US$1.38	=	SDR 1

FISCAL YEAR
July 1 - June 30

Regional Vice President:	Hafez M. H. Ghanem
Country Director:	Mara K. Warwick
Regional Director:	Amit Dar
Practice Manager:	Ernest E. Massiah
Task Team Leader:	Peter Okwero
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ABBREVIATIONS AND ACRONYMS

ANC	Antenatal Care
ANIS	Achieving Nutrition Impact at Scale
BEmONC	Basic Emergency Obstetric and Neonatal Care
BRN	Big Results Now
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CHMT	Council Health Management Team
CPF	Country Partnership Framework
DHFF	Direct Health Financing Facility
DHIS	District Health Information System
DHS	Demographic and Health Survey
DLI	Disbursement-Linked Indicator
DLR	Disbursement-Linked Result
DP	Development Partner
DQA	Data Quality Audits
E&S	Environmental and Social
ESSA	Environmental and Social Systems Assessment
FM	Financial Management
FSA	Fiduciary Systems Assessment
GDP	Gross Domestic Product
GFF	Global Financing Facility
GNI	Gross National Income
GOT	Government of Tanzania
GRM	Grievance Redress Mechanism
HBF	Health Basket Fund
HRH	Human Resources for Health
HSSP	Health Sector Strategic Plan
ICR	Implementation Completion and Results Report
ICT	Information and Communication Technology
IDA	International Development Association
IFMIS	Integrated Financial Management Information System
IRI	Intermediate Results Indicator
ISR	Implementation Status and Results Report
IPT	Intermittent Preventive Treatment
LGA	Local Government Authority
M&E	Monitoring and Evaluation
MDG	Millennium Development Goal
NKRA	National Key Results Area
MKUKUTA	Tanzania's National Strategy for Growth and Poverty Reduction
MNCH	Maternal, Neonatal, and Child Health
MOFP	Ministry of Finance and Planning
MoHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
MoHSW	Ministry of Health and Social Welfare
MSD	Medical Stores Department
MTR	Mid-Term Review

PAD	Program Appraisal Document
PDO	Program Development Objective
PDOI	Program Development Objective Indicator
PforR	Program for Results
PHC	Primary Health Care
PMORALG	Prime Minister's Office - Regional Administration and Local Government
PORALG	President's Office - Regional Administration and Local Government
PRF	Program Results Framework
RA	Result Area
RBF	Results-Based Financing
RHMT	Regional Health Management Team
RMNCAH	Reproductive, Maternal, Neonatal, Child and Adolescent Health
SWAp	Sector-Wide Approach
SDG	Sustainable Development Goal
TA	Technical Assistance
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

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DATA SHEET

BASIC INFORMATION

Product Information

Program ID	Program Name	Financing Instrument
P152736	Strengthening Primary Health Care for Results	Program-for-Results Financing

Country	IPF Component
Tanzania	No

Organizations

Borrower	Implementing Agency
United Republic of Tanzania	President's Office Regional Administration and Local Government, Ministry of Health, Community Development, Gender, Elderly and Children

Program Development Objective (PDO)

Original PDO

The Program Development Objective is to improve the quality of primary health care (PHC) services nationwide with a focus on maternal, neonatal and child health (MNCH) services.

FINANCING

	Original Amount (US$)	Revised Amount (US$)	Actual Disbursed (US$)
World Bank Administered Financing			
IDA-56430	200,000,000	200,000,000	186,238,167
TF-A0261	20,000,000	20,000,000	14,539,423
TF-A0270	40,000,000	40,000,000	34,043,509
TF-A1567	4,500,000	3,978,270	3,978,270
TF-A9831	10,021,343	6,199,092	6,199,092
Total	**274,521,343**	**270,177,362**	**244,998,461**
Non-World Bank Administered Financing			
Borrower/Recipient	0	0	0
Total	**0**	**0**	**0**
Total Program Cost	**274,521,343**	**270,177,362**	**244,998,461**

KEY DATES

Program	Approval	Effectiveness	MTR Review	Original Closing	Actual Closing
P152736	28-May-2015	05-Nov-2015	18-May-2018	30-Jun-2020	30-Jun-2021

RESTRUCTURING AND/OR ADDITIONAL FINANCING

Date(s)	Amount Disbursed (US$M)	Key Revisions
16-Jan-2020	199.08	Change in Results Framework Change in Loan Closing Date(s) Reallocation between and/or Change in DLI Change in Program Action Plan Change in Institutional Arrangements Change in Implementation Schedule Other Change(s)

KEY RATINGS

Outcome	Bank Performance	M&E Quality
Moderately Satisfactory	Moderately Satisfactory	Substantial

RATINGS OF PROGRAM PERFORMANCE IN ISRs

No.	Date ISR Archived	DO Rating	IP Rating	Actual Disbursements (US$M)
01	10-Sep-2015	Satisfactory	Satisfactory	.25
02	17-Mar-2016	Satisfactory	Satisfactory	26.69
03	05-Oct-2016	Satisfactory	Moderately Satisfactory	60.67
04	02-May-2017	Satisfactory	Satisfactory	100.34
05	28-Dec-2017	Satisfactory	Satisfactory	110.34
06	30-Jun-2018	Satisfactory	Moderately Satisfactory	158.26
07	20-Dec-2018	Satisfactory	Moderately Unsatisfactory	166.93
08	28-Jun-2019	Satisfactory	Moderately Unsatisfactory	191.69
09	19-Dec-2019	Satisfactory	Moderately Satisfactory	200.66
10	26-Jun-2020	Satisfactory	Moderately Satisfactory	218.74
11	14-Dec-2020	Satisfactory	Moderately Unsatisfactory	224.94
12	30-Jun-2021	Moderately Satisfactory	Moderately Unsatisfactory	238.88

SECTORS AND THEMES

Sectors

Major Sector/Sector	(%)
Health	**100**
Health	100

Themes

Major Theme/ Theme (Level 2)/ Theme (Level 3)	(%)

Human Development and Gender	**101**
Health Systems and Policies	85
Health System Strengthening	35
Reproductive and Maternal Health	25
Child Health	25
Nutrition and Food Security	16
Nutrition	8
Food Security	8

ADM STAFF

Role	At Approval	At ICR
Regional Vice President:	Makhtar Diop	Hafez M. H. Ghanem
Country Director:	Philippe Dongier	Mara K. Warwick
Director:	Timothy Grant Evans	Amit Dar
Practice Manager:	Abdo S. Yazbeck	Ernest E. Massiah
Task Team Leader(s):	Rekha Menon, Son Nam Nguyen	Peter Okwero
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I. PROGRAM CONTEXT AND DEVELOPMENT OBJECTIVES

A. CONTEXT AT APPRAISAL AND THEORY OF CHANGE

Country Context

1. At the time of this program's preparation in mid-2015, Tanzania's economy was experiencing strong growth and relative stability, with a gross domestic product (GDP) growth averaging 6.45 percent during the preceding decade (2005-2014) and inflation under control (5.6 percent in 2015).[1] Fiscal space, however, was tight as a result of lower-than-expected domestic revenue collection, diminishing aid, and higher investment in infrastructure projects. Likewise, poverty had only decreased marginally from 34 percent in 2007 to 28 percent in 2012, with 44 percent of the population still living on less than US$1.25 per day and 90 percent, on less than US$3 per day. Among the factors limiting poverty reductions in a context of economic growth were slower than expected improvements in human capital in income-generation opportunities and a lack of growth in labor-intensive sectors, including manufacturing and agriculture in rural areas where 84 percent of poor households resided.

2. In 2000, Tanzania adopted the Tanzania *Development Vision 2025* with the aim of building a society characterized by: (i) quality livelihoods; (ii) peace, stability, and harmony; (iii) good governance and rule of law; (iv) an educated and learning population; and (v) a vibrant and competitive economy by 2025. Likewise, Tanzania's *National Strategy for Growth and Poverty Reduction* (MKUKUTA II 2010 –2015) had three priorities: (i) growth and reduction of income poverty; (ii) improvement of quality of life and social well-being; and (iii) good governance and accountability. It explicitly identified improvements in human resources for health, maternal health, health facilities and service delivery as national priorities.

Sectoral and Institutional Context

3. *Sectoral context* - Over the preceding decade, Tanzania had successfully reduced mortality rates in younger groups, surpassing the Millennium Development Goal (MDG) related to child mortality. Between 1999 and 2015/16, infant mortality fell from 99 to 43 per 1,000 live births, while under-five mortality declined from 147 to 67 per 1,000 live births.[2] Despite such progress, Tanzania's health outcomes were still lower than expected for its level of economic development. Maternal mortality ratio remained high at 556 deaths per 100,000 live births in 2015/16 against a backdrop of low coverage of facility deliveries and family planning. Likewise, while neonatal mortality rate was lower than in peer countries,[3] it was still high at 25 per 1,000 live births.[2, 4] Stunting also remained persistently high (34 percent among children under five years of age), increasing markedly with a child's age.[5]

4. Low quality of care also remained a major bottleneck, with poor compliance with service standards. According

[1] International Monetary Fund (IMF). [https://www.imf.org/en/Countries/TZA#countrydata]
[2] Tanzania Demographic and Health Survey (DHS), 2015/16.
[3] Peer countries are 14 countries close to Tanzania in the global ranking of economic development (7 immediately above and 7 immediately below).
[4] Kruk ME, Rockers PC, Mbaruku G, Paczkowski MM, and Galea S. (2010), "Community and Health System Factors Associated with Facility Delivery in Rural Tanzania: A Multilevel Analysis," *Health Policy*, October 2010.
[5] Tanzania's DHS 2015/16.

to the 2012 Service Availability and Readiness Assessment, only 32.3 percent of dispensaries and 50 percent of health centers had the capacity to provide basic emergency obstetric and neonatal care services (BEmONC). Among all hospitals, only 73 percent met comprehensive emergency obstetric and neonatal care (CEmONC) service standards. A range of factors contributed to low quality of care. First, Tanzania had relatively low public spending on health (8.7 percent in 2013/14), with health financing being highly dependent on external support (equivalent to 48 percent of total public expenditure on health in 2011/12) that was fragmented and mostly off-budget. Second, skilled human resources in the health sector were both insufficient and inequitably distributed, with an average ratio of seven clinicians and nurses per 10,000 population (a third of the 23 recommended by the World Health Organization – WHO) and as many as 45 percent of the country's doctors serving the Dar es Salaam area, which accounted for roughly 10 percent of the country's population. Third, decentralization in the health sector had not yet fully materialized, with facilities often not receiving the health funds that were being channeled through local government authorities (LGAs) and, when they did, having limited financial autonomy regarding their utilization. Fourth, accountability for results was low at all levels, including at the local and facility levels, resulting in high levels of absenteeism, lack of adherence to good clinical practices, essential drugs being frequently out of stock and health facilities in poor conditions.

5. Since its inception in 1999, Tanzania's Health Basket Fund (HBF) has provided coordinated donor support to the efforts of the Government of Tanzania (GOT) to strengthen primary health care services. Specifically, this pooling mechanism of donor resources supports the implementation of the national health strategies using a Sector-Wide Approach (SWAp) to enhance coordination among Development Partners (DPs) and the GOT in terms of financing, planning, and monitoring mechanisms. As one of the funding members and a major contributor, the World Bank has played a central role within the HBF, with its health sector operations contributing to the HBF under the SWAp approach.

6. *Institutional context* – The Ministry of Health and Social Welfare (MoHSW), which was renamed the Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC) in late 2015, as the steward of the health system, is responsible for health policies, strategies, regulations, coordination and oversight for the sector and the program. It leads the development of health sector strategic plans and the medium-term expenditure framework, which forms the basis for health sector budget allocations on a rolling basis. MoHCDGEC also exerts stewardship functions over various health agencies such as the Medical Stores Department (MSD), the Tanzania Food and Drugs Authority, and the National Health Insurance Fund.

7. The Prime Minister's Office, Regional Administration and Local Government (PMORALG), renamed the President's Office, Regional Administration and Local Government (PORALG) in late 2015, is responsible for coordinating, providing administrative support and allocating resources for the delivery of PHC services through LGAs. At the time of preparation, funds for development and recurrent expenses were transferred from the Treasury to the LGAs, and from the LGAs to the health facilities. LGAs are responsible for ensuring proper accounting at the facility level. In this context, the roles of PORALG are to: (i) support LGAs in the provision of quality health services; (ii) manage the critical interfaces with the Ministry of Finance and Planning (MOFP), MoHCDGEC, DPs and LGAs; (iii) monitor the support by Regional Administrative Secretariats to LGAs; and (iv) provide advice, information and capacity building to RAS and LGAs in policies, approaches, systems and planning methodologies. The Council Health Management Team (CHMT) plays an important role in planning and decision-making at the LGA level. It manages

district health services and reports to the District Council. At the regional level, the roles of the Regional Health Management Team (RHMT) are to: (i) provide technical support to LGAs; (ii) identify capacity building needs; and (iii) monitor, supervise, and evaluate health services, including data quality audits.

8. Health facilities (public, faith-based and private) at the LGA level are responsible for delivering PHC services, in line with Tanzania's decentralized health service delivery system.[6] Public health care provision reflects the country's political-administrative hierarchy. At the village level, there are dispensaries, with village leaders having a direct influence on their operation. At the ward level, there are health centers, with the health center in charge being answerable to the ward leaders. At the district, there is a district hospital and at the regional level, a regional referral hospital. The tertiary hospitals are at the zonal and national levels. There are also some specialized hospitals directly under the MoHCDGEC.

9. *Health sector policies* - The Mid-Term Review (MTR) of Tanzania's *Third Health Sector Strategic Plan* (HSSP III) FY09-FY15 concluded that, while the health sector had made progress in all strategic areas, the pace had been slower than anticipated. Overall, there had been more progress in systems development (policies, strategies, guidelines, work plans, etc.) than in service delivery, with innovations slowly trickling down to front-line health facilities. Vertical disease control programs had performed better than either general or reproductive health services. The MTR identified two priority areas: (i) improving value for money by making optimal use of available resources for better quality; and (ii) increasing transparency and accountability for results (including community engagement). The MTR also emphasized the need to improve health outcomes through sustainable service delivery systems.

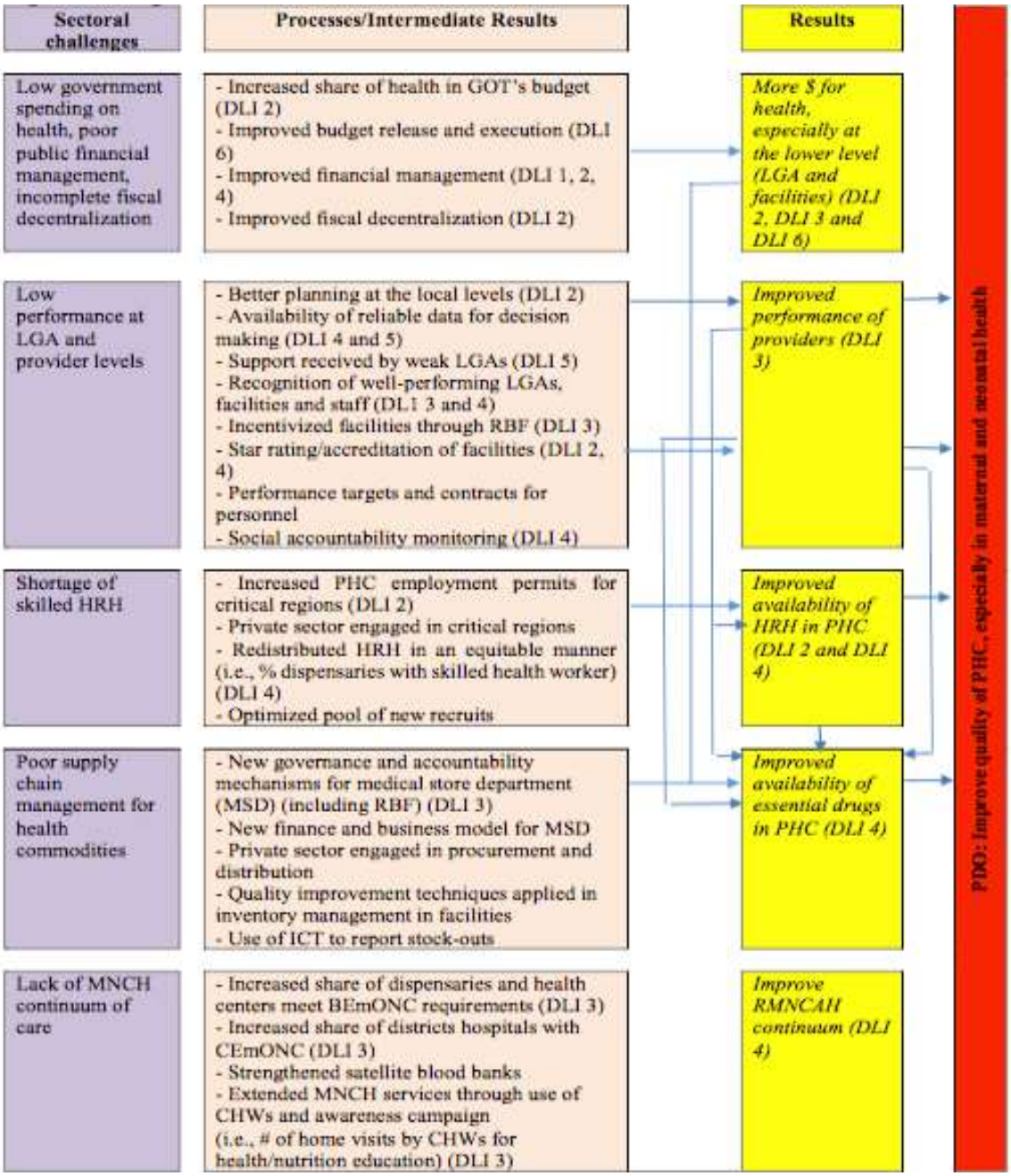
10. To address the health system challenges identified by the MTR, the GOT embarked on a high-profile initiative, the so-called *Big Results Now in Health 2015-2018* (BRN in Health), with the aim of accelerating the reduction of maternal and neonatal mortalities by improving performance, governance and accountability in PHC. The BRN in Health was also embedded in the medium-term *Fourth Health Sector Strategic Plan* (HSSP IV) that was to guide Tanzania's health sector development during the FY16-FY20 period. This Program-for-Results (PforR) operation was conceived to support implementation of the GOT's PHC program for the 2015/16 – 2019/20 period, with a strong focus on the BRN in Health initiative.

Theory of Change (Results Chain)

11. The operation's Theory of Change is fully captured in the diagram included in the operation's Program Appraisal Document (PAD). As shown in Figure 1, the operation applied the Bank's PforR methodology to improve the quality of PHC services nation-wide with a focus on maternal, neonatal and child health (MNCH) services, identifying and addressing the main weaknesses preventing the achievement of this development objective to: (i) ensure adequate, more transparent funding at local and facility levels; (ii) improve the performance at the LGA and health facility levels (iii) improve the availability of human resources in PHC; (iv) improve the availability of essential medicines in PHC; and (v) improve the MNCH continuum of care.

[6] Manzi F. et al. (2012), "Human resources for health care delivery in Tanzania: a multifaceted problem," *Human Resources for Health*, 2012 Feb 22;10:3. [https://pubmed.ncbi.nlm.nih.gov/22357353/]

Figure 1. Theory of Chain for Tanzania's Strengthening Primary Health Care for Results Program



Rationale for PforR Support, and Program Scope and Boundaries

12. The selection of the PforR instrument for this operation was based on the following reasons: (i) focus towards policies and sector-wide results rather than on specific inputs; (ii) consistency with the GOT's commitment to results

in the health sector as reflected in the BRN in Health initiative; (iii) increased flexibility and responsiveness to the country's needs though the provision of non-earmarked funds; (iv) utilization of country systems with due attention to systems strengthening, which offered potential for greater development impact and sustainability; and (v) motivation for country implementers to find locally relevant and sustainable solutions to overcome operational bottlenecks to the achievement of results.

Program Development Objectives (PDOs)

13. The Program Development Objective as stated in the Financing Agreement (5643-TZ) was to improve the quality of primary health care (PHC) services nationwide in the Recipient's territory with a focus on maternal, neonatal and child health (MNCH) services.

Key Expected Outcomes and Outcome Indicators

14. The success of the program was to be measured by the following five PDO Indicators (PDOIs):[7]

- PDOI 1. Percentage of PHC facilities with 3-star rating and above[8]
- PDOI 2. Percentage of expected pregnant women attending four or more antenatal care (ANC) visits
- PDOI 3. Percentage of ANC attendees receiving at least two doses of intermittent preventive treatment (IPT2) for malaria
- PDOI 4. Percentage of institutional deliveries
- PDOI 5. Percentage of children 12-59 months of age receiving vitamin A supplementation

15. In addition, the Program Results Framework (PRF) included 12 intermediate results indicators (IRIs) to track improvements in service delivery and performance as well as 7 disbursement-linked indicators (DLIs).

Program Results Areas and DLIs

16. *Government Program:* The 2015-2018 BRN in Health Program aimed to accelerate the reduction of maternal and neonatal mortalities by improving performance, governance and accountability in PHC. The BRN in Health was developed as part of Tanzania's Development Vision 2025 and had four national key results areas (NKRAs), as follows:

- *NKRA 1 - Performance Management*: This result area aimed to improve health workers' performance through the implementation of: (i) an assessment scheme for all PHC facilities in the country (the "Star Rating" initiative), including a nation-wide assessment and a subsequent facility improvement program to help facilities improve their performances and star ratings; (ii) the Decentralization by Devolution Policy by empowering health facilities to plan, budget and manage revenue in line with the Health Cost Sharing Guidelines; (iii) performance contracts and targets at individual health worker levels; and (iv) social accountability mechanisms.

[7] Percentage of dispensaries with skilled HRH was listed as a PDO Indicator in the main text of the PAD (p. 11), but as an Intermediate Results Indicator (IRI) in Annex 2 (p. 46). It is also listed as an IRI in all the ISRs and the 2020 restructuring. Thus, it is considered an IRI.

[8] The Star Rating Assessment is a quality improvement approach designed to assess performance of health facilities in a stepwise manner. Performance scores assessing quality of RMNCH at the facility level included four domains: (i) facility management and staff performance; (ii) service charters and accountability; (iii) safe and conducive facilities; and (iv) quality of care and services, including interviews with patients and spot checks of medical records to verify the quality of content of care and recording. The "Star Rating" assessment scale is from 1 to 5 stars, with 5 being the best quality and 3 being minimally acceptable.

This NKRA was in line with the HSSP IV and the draft Health Financing Strategy, both of which incorporated a Results-Based Financing (RBF) approach aimed at providing incentives and enhancing accountability at the facility level by providing them with quarterly payments according to their levels of achievement with respect to a set of performance indicators subject to their independent verification.[9]

- *NKRA 2 - Human Resources for Health (HRH)*: This result area aimed to improve the distribution of skilled PHC workers, especially in nine regions with critical shortages by: (i) increasing PHC employment permits for such regions; (ii) engaging the private sector to provide skilled HRH for public health facilities; (iii) redistributing health care workers within regions; and (iv) optimizing the pool of new recruits through "bonding" policy or compulsory attachments.

- *NKRA 3 - Health Commodities*: This result area aimed to improve the availability of essential medicines in PHC facilities by addressing key issues along the health commodities supply chain, including: (i) introducing new governance and accountability mechanisms; (ii) developing a new finance and business model for MSD; (iii) engaging private sector in procurement and distribution; (iv) implementing quality improvement initiatives for inventory management; and (v) using innovative information and communication technology (ICT) to report stock-outs.

- *NKRA 4 - Maternal, Neonatal and Child Health*: This result area aimed to improve the coverage and quality of MNCH along the continuum of care by: (i) ensuring the dispensaries and health centers meet BEmONC requirements; (ii) expanding CEmONC to select hospitals and health centers; (iii) strengthening the corresponding satellite blood banks which serve facilities with CEmONC; and (iv) extending MNCH services to communities through the use of community health workers and awareness campaigns. Priority focus was given to the five worst performing regions.

17. *Scope and program boundaries:* This PforR operation was fully aligned both in terms of time frame and scope with the GOT's five-year program for the PHC component under HSSP IV, including the BRN in Health. Thus, this PforR operation supported the GOT's 2015-2018 BRN in Health in its entirety. The rationale for supporting the entire program was based on: (i) the close linkages of many PHC activities and initiatives under HSSP IV; (ii) the levels of World Bank's past engagement and added value; and (iii) the need to maintain a reasonable ratio of International Development Association (IDA) financing vis-à-vis the overall cost of the GOT program. While the operation as a whole supported all of Tanzania's 26 regions, the RBF was to be rolled out in a phased manner covering nine regions by 2020.

18. In addition to the four NKRAs, this PforR operation included two additional Results Areas (RAs) to complement the four NKRAs under the GOT program: (i) health financing and public financial management (FM) to ensure adequate levels of spending and transparent FM in health; and (ii) monitoring and evaluation (M&E), supervision and capacity building to foster accountability and governance (see Table 1).

Table 1: Results Areas under the GOT BRN in Health Program and the PforR Operation

2015-2018 BRN in Health Program	Strengthening PHC PforR

[9] The design of the RBF strategy was informed by a pilot conducted in Pwani region with support from the government of Norway. An independent impact evaluation of the pilot (conducted between 2011 and 2013) showed promising results, with significant positive effects on a range of incentivized services.

	RA 1. Health Financing and Public Financial Management
NKRA 1. Performance Management	RA 2. Performance Management
NKRA 2. Human Resources for Health	RA 3. Human Resources for Health
NKRA 3. Health Commodities	RA 4. Supply Chain Management*
NKRA 4. Maternal, Neonatal and Child Health	RA 5. Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH) Continuum*
	RA 6. M&E, Supervision and Capacity Building

* Although named differently, there are no substantive differences with the corresponding NKRAs.

19. DLIs: The Bank and the GOT had agreed on seven DLIs and the corresponding targets to determine the disbursement of funds, as shown in Table 2:

Table 2: Key Expected DLIs

Disbursement-Linked Indicators (DLIs)	Disbursement Schedule	Original Allocations US$ million (% of total proceeds) *
DLI 1. Recipient has completed all foundational activities	Years 1, 2	20.0 (6.7%)
DLI 2. Recipient has achieved all the Program annual results in institutional strengthening at all levels (national, regional, LGA and facilities)	Years 1, 2, 3, 4, 5	75.0 (25.0%)
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	Years 1, 2, 3, 4, 5	100.0 (33.3%)
DLI 4. LGAs have improved annual maternal, neonatal and child health service delivery and quality as measured by the LGA Balance Score Card	Years 2, 3, 4, 5	82.0 (27.3%)
DLI 5. Regions have improved annual performance in supporting PHC services as measured by regional Balance Score Card	Years 2, 3, 4, 5	2.4 (0.8%)
DLI 6. MoHCDGEC and PORALG have improved annual PHC service performance as measured by the national Balance Score Card	Years 2, 3, 4, 5	5.6 (1.9%)
DLI 7. Completion of annual capacity building activities at all levels as per the agreed annual plans	Years 2, 3, 4, 5	15.0 (5.0%)

Source: Table 4: Summary of Disbursement Linked Indicators (PAD, pp. 13-14).

* Estimated at US$300 million at Appraisal, including IDA (US$200 million), USAID Trust Fund (US$40 million), as well as financing from Global Financing Facility (GFF, US$40 million) and Achieving Nutrition Impact at Scale (ANIS) Multi-Donor Trust Fund (US$20 million).

B. SIGNIFICANT CHANGES DURING IMPLEMENTATION

Revised PDOI Targets, Result Areas, and DLIs

20. The operation underwent a Level 2 restructuring in January 2020. While the PDO and main results areas remained unchanged, PDOI end-targets and DLIs were modified. The main changes introduced under the 2020 restructuring are summarized as follows:

21. *Changes in the Program Results Framework (PRF):* The PRF was revised during restructuring to: (i) incorporate the findings of a validation exercise of the Program baseline data and end targets carried out in the first year of implementation; (ii) adjust end targets to more realistic expectations based on the revised baselines and implementation experience – for the most part, targets were revised upwards except for 1 PDO and 1 Intermediate outcome indicator; and (iii) reflect a greater emphasis toward ensuring functionality of the refurbished health facilities (IRI 9). In addition, IRI 6 - *Annual employment permits for PHC given to the nine critical regions* was dropped, as the mandate for recruitments was outside the control of the MoHCDGEC. Finally, operational definitions for IRIs 8, 9 and 12 were modified for further clarification and to enhance the focus on results. Of the 22 indicators (including four corporate results indicators), the targets for 11 of them were increased and the targets for 2 of them were reduced, with 8 indicators remaining the same and one dropped. Baselines were revised for 2 indicators. The specific changes in the PRF are shown on Table 3:

Table 3. Changes to the Program Results Framework under the 2020 Restructuring

Program Development Objective Indicators (PDOIs)	Unit	Baseline 2014/15	Revised Baseline	Original Target	Revised Target
PDOI 1. PHC facilities with 3-star ratings and above	%	0	No Change	50	30
PDOI 2. Pregnant women attending four or more ante-natal care (ANC) visits	%	41.2	No Change	60	68
PDOI 3. Institutional Deliveries	%	44.72	No Change	60	70
PDOI 4. ANC attendees receiving at least 2 doses of intermittent preventive treatment (IPT2) for Malaria	%	42.52	No Change	60	80
PDOI 5. Proportion of children 12-59 months receiving at least one dose of Vitamin A supplementation during the previous year	%	51	No Change	65	90
	Intermediate Results				
	Results Area 1. Health financing, public financial management				
IRI 1. Share of health in total government budget	%	8.5	No Change	9.75	No Change
IRI 2. Councils with unqualified opinion in the annual external audit report	%	80	No Change	90	92
	Results Area 2. Performance Management				
IRI 3. Completion of "Star rating" assessment of PHC facilities as per the two-year cycle (cycle 1 -0/ cycle 2 -0)	%	0	No Change	50	No Change
IRI 4. RBF facilities receiving timely RBF payment on the basis of verified results every quarter	%	0	No Change	95	100
IRI 5. LGAs with functional Council Health Service Boards	%	86.3	No Change	100	No Change
	Results Area 3. Human Resources for Health (HRH)				
IRI 6. Annual employment permits for PHC given to the 9 critical regions	%	32	No Change	30	Dropped
IRI 7. Dispensaries with skilled HRH	%	91	No Change	100	No Change
	Results Area 4. Supply chain management				

IRI 8. Health facilities with continuous availability of the tracer medicines in the past year *(based on MoHCDGEC medicine list)*	%	30.6	No Change	55	80
Results Area 5. RMNCAH continuum					
IRI 9. Health facilities with *functional* CEmONC	Number	79	0	104	160
Results Area 6. M&E, supervision, and capacity building					
IRI 10. Completeness of quarterly HMIS data entered in District Health Information System (DHIS) by LGA (by the end of month after quarterly ends)	%	89.5	No Change	95	96
IRI 11. RHMT's required biannual data quality audits (DQA) for LGAs that meet national DQA standards.	%	0	No Change	90	80.0
IRI 12. RHMT's conduct *quarterly* supportive supervision visits for LGAs that meet national supervision standards *and is reported in in the DHIS2*	%	0	No Change	90	100
IRI 13. Completion of annual capacity building activities compared to agreed annual plans.	%	N.A.	0	90	100
Other (Corporate Results Indicators)					
IRI 14. People who have received essential health, nutrition and population services	Number	0	No Change	30 million	No Change
IRI 15. Number of children immunized	Number	0	No Change	10 million	No Change
IRI 16. Number of women and children who have received basic nutrition services	Number	0	No Change	10 million	No Change
IRI 17. Number of women and children who have received basic nutrition services	Number	0	No Change	10 million	No Change

Source: Baselines and original targets reflect Annex 2 in the PAD; revised targets reflect Annex 1 in the Restructuring Paper (Report No. RES36717). Corporate results indicators were added to the results framework in December 2018.

22. *Modifications to DLIs:* The 2020 restructuring also introduced several modifications to the DLIs, although none of these changed the objective of these DLIs. The changes made also included an increase in the total financial support from US$300 million to US$306 million to account for an increase in the actual amount of USAID's contribution.[10] Other modifications included:

- *Reallocation of funds:* The original allocation of funds among DLIs was modified as follows: (i) additional funds were reallocated for DLIs 1, 5, and 6 (US$15 million for DLI 1; US$700,000 for DLI 5; US$800,000 for DLI 6); (ii) the original allocation of funds was reduced for DLIs 2, 3 and 4 (US$10 million for DLI 2; US$19 million for DLI 3;

[10] Total financial support was estimated at US$300 million at Appraisal, including IDA (US$200 million), USAID Trust Fund (US$40 million), as well as financing from Global Financing Facility – GFF (US$40 million) and Achieving Nutrition Impact at Scale (ANIS) Multi-Donor Trust Fund (US$20 million).
Two factors contribute to differences in reporting of USAID financial contribution. First, the actual financial agreement with USAID, which was signed after Appraisal, was for US$46 million, for which total financial support increased to US$306 million. Second, while USAID committed US$46 million as per the Administrative Agreement, it operated on an annual budget cycle; thus, the Bank therefore only signed Grant Agreements with GOT on the basis of the funds obligated by USAID (i.e., TF0A1567 for US$4.5 million and TF0A9831 for US$10.0 million).

and US$1.5 million for DLI 4): and (iii) US$20 million was unallocated to allow for a reduction in USAID funding[11] (see Table 4). The payment periods for DLIs were extended to the revised closing date of June 30, 2021.

- *Changes in DLIs:* Some modifications were introduced in the DLIs, as follows:
  DLI 1 – The definition was revised to "Recipient has completed foundational activities." Since the original Disbursement-Linked Results (DLRs) had been completed, a new DLR was added (DLR 1.7 - Recipient has made refurbished health facilities' CEmONC *functional*), with a US$262,500 disbursement for each facility with CEmONC made *functional* (these facilities were different from the eight facilities that met CEmONC standards and triggered payment under DLI 1 previously).
  DLI 2 - The definition was revised to "Recipient has achieved Program annual results in institutional strengthening" to drop the all-or-nothing principle and introduce scalability. In addition, DLR 2.5 - Annual employment permits for PHC given to the nine critical regions" was dropped since, as noted earlier, it is outside the authority of the MoHCDGEC; and a new one was added (DLR 2.7 - Recipient has carried out annual audit of procurement contracts").
  DLI 3 - The payment framework was revised to exclude a 28-day time frame for RBF payment.
  DLI 4 - The payment calculation formula was simplified and revised to reward health facilities that maintained high-level performance (greater than 80 percent).
- Finally, to enhance cost-savings and efficiency, the counter-verification sample size was reduced from 25 percent to 10 percent of the health facilities in the selected areas.

Table 4. Changes to Disbursement-Linked Indicators under the 2020 Restructuring

Disbursement-Linked Indicators			Disbursement Schedule (Years)	Allocations (US$ million)
DLI 1.	Recipient has completed all foundational activities	Original	1, 2	20.00
		Revised	1, 2, 5, 6	35.00
DLI 2.	Recipient has achieved all of the Program annual results in institutional strengthening at all levels (national, regional, LGA and facilities)	Original	1, 2, 3, 4, 5	75.00
		Revised	1, 2, 3, 5, 6	65.00
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	Original	1, 2, 3, 4, 5	100.00
		Revised	1, 2, 3, 4, 5, 6	81.00
DLI 4.	LGAs have improved annual maternal, neonatal and child health service delivery and quality as measured by the LGA Balance Score Card	Original	2, 3, 4, 5	82.00
		Revised	2, 3, 4, 5, 6	80.50
DLI 5.	Regions have improved annual performance in supporting PHC services as measured by regional Balance Score Card	Original	2, 3, 4, 5	2.40
		Revised	2, 3, 4, 5, 6	3.10
DLI 6.	MoHCDGEC and PORALG have improved annual PHC service performance as measured by the national Balance Score Card	Original	2, 3, 4, 5	5.60
		Revised	2, 3, 4, 5, 6	6.40
DLI 7.	Completion of annual capacity building activities at all levels as per the agreed annual plans	Original	2, 3, 4, 5	15.00
		Revised	2, 3, 4, 5, 6	15.00

[11] USAID funding supported the implementation of the RBF in two regions. At the time of restructuring, USAID had announced its intention to reduce its original pledge given that delay in RBF payments made the full utilization of funds highly unlikely.

Total		Original	Total	300.00
		Revised	Total	306.00
			- Allocated	286.00
			- Unallocated	20.00

* Estimated at US$306 million at Appraisal, including IDA (US$200 million), USAID Trust Fund (US$46 million), GFF (US$40 million) and ANIS Multi-Donor Trust Fund (US$20 million).

23. *Extension of the Program closing date:* The Program closing date was extended from June 30, 2020 to June 30, 2021 to align the last DLI payments with a full annual implementation cycle, providing government adequate time to complete verification and submit the payment notification. The closing date extension applied to IDA, GFF and the Achieving Nutrition Impact at Scale (ANIS) Multi-donor Trust Fund but did not apply to the USAID Grant.

Other Changes

24. In addition to the IDA credit (Credit No. IDA-56430; US$200 million), three grants from the following sources contributed to the financing the PforR Program: (i) Multi-Donor Trust Fund for the Global Financing Facility (GFF) in Support of Every Woman Every Child Project (Grant No. TF0A0270; US$40 million); (ii) the United States Agency for International Development - USAID (Grant No. A1566; up to US$46 million); and (iii) ANIS Multi-donor Trust Fund (Grant No. TF0A0261; US$20 million). In total USAID disbursed US$10.2 million out of the original indicative amount of US$46 million to support two out of nine regions implementing RBF. Given the slowdown in the implementation of the RBF, the full amount could not be absorbed (see further discussion under Section III.B). Thus, the overall Program's envelope was scaled down from US$306 million to US$270,177,362.

Rationale for Changes and their Implication for the Original Theory of Change

25. The original Theory of Change remained unchanged.

II. OUTCOME

A. RELEVANCE

Relevance of PDO

Rating: High

26. With its focus on quality of PHC, MNCH in particular, the operation's PDO continues to be **highly relevant**, as reflected in the current policy priorities of both the Bank and the GOT. Specifically, the operation's PDO is fully consistent with two of the three Focus Areas of the Bank's Country Partnership Framework (CPF) FY18-22.[12] Specifically, the PDO is in alignment with Focus Area 2 - Boost Human Capital and Social Inclusion, which adopts a lifecycle approach to human development challenges, giving particular emphasis to investing in the early years, including health and nutrition (Objective 2.1) and improving the quality of health care and education (Objective 2.2). Although not explicitly indicated in the PDO, the operation's emphasis on enhancing performance management within

[12] World Bank Group (2018), *Country Partnership Framework for the United Republic of Tanzania for the Period FY18-FY22.* World Bank, Washington, DC. [https://openknowledge.worldbank.org/handle/10986/29600]

Tanzania's health sector is also in alignment with Focus Area 3 - Modernize and Improve the Efficiency of Public Institutions, which assigns high priority to reinvigorating public sector reform, with a particular emphasis on strengthening public sector accountability and financial efficiency in delivering services (Objective 3.1).

27. The operation's PDO also continues to be highly relevant in relation to Tanzania's national development agenda and the priorities within the health sector. Specifically, quality of PHC services, MNCH in particular, for all its citizens is an implicit pre-requisite for the achievement of Tanzania Development Vision 2025,[13] which envisions high-quality livelihood for its citizens, peace, stability and unity, good governance, a well-educated and learned society and a competitive economy capable of producing sustainable growth and shared benefits. The PDO is also consistent with Tanzania's National Five-Year Development Plan 2021/22 - 2025/26 "Realizing Competitiveness and Industrialization for Human Development," which sets as one of the targets to improve quality of life and human wellbeing.[14] Finally, the PDO also supports the 2021-2026 Fifth Health Sector Strategic Plan (HSSP V) "Leaving No One Behind," which envisions a healthy and prosperous society that contributes fully to the development of individuals and the nation.[15] The HSSP V 's specific goal is to provide sustainable health services with standards that are acceptable to all citizens without financial constraints, based on geographical and gender equity. Improved governance and accountability, as well as increased focus on primary health, MNCH in particular, continued to be central elements of the HSSP V.

28. The operation's PDO, with a focus on MNCH, was and remains central to the attainment of Sustainable Development Goal (SDG) 3 – Good Health and Wellbeing for All at All Ages as well as the achievement of Agenda 2063 of the African Union, with its goal of improving the health of the population.

29. Split evaluation methodology: Although some PDOI targets were modified during the 2020 restructuring, a split evaluation is not merited in this case, mainly because the majority of the targets were revised upwards and because PDOI achievement is the same for the pre- and post-restructuring periods.

Relevance of DLIs

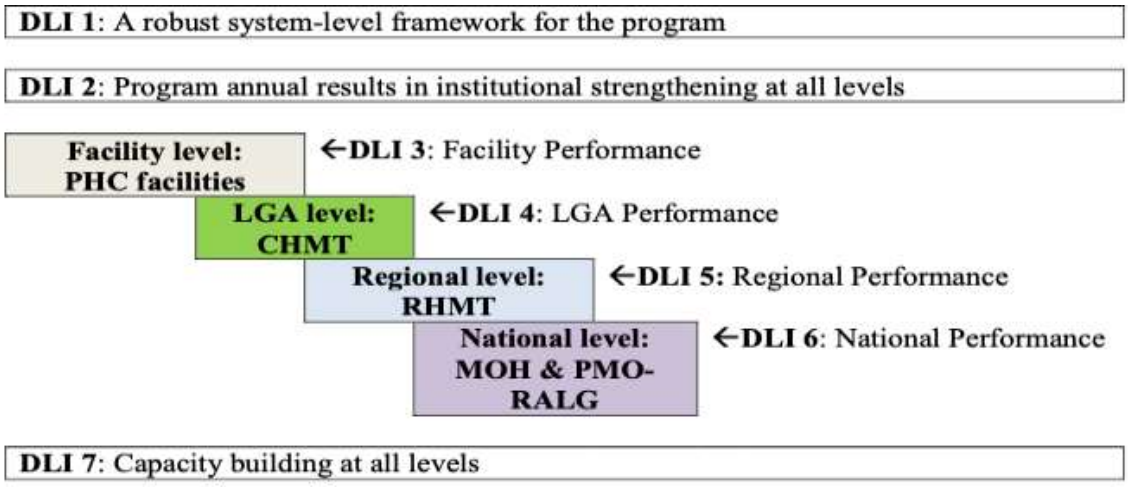
Relevance: High

30. The relevance of the DLIs is deemed High. The operation included seven DLIs that provided a solid platform for performance-based financing at different levels in Tanzania's health system. Three DLIs (DLIs 1, 2 and 7) included a combination of actions and intermediate results aimed at improving the conditions for quality of care, while the remaining four DLIs (3, 4, 5 and 6) focused on performance outcomes (in terms of coverage and quality) at the facility, LGA, regional and national levels. Together, they reflected the operation's Results Chain (see Figure 2), supporting the achievement of intermediate results and the PDO. The criteria by which they were selected contributed to their relevance, including: (i) maximum use of existing indicators in the government's program; (ii) correspondence to the key priority PHC areas in the HSSP IV, providing incentives for removing the major bottlenecks along the Results Chain; (iii) results-focus to stimulate performance at all levels of the system; (iv) prioritization of government's routine information system (DHIS) and existing reporting mechanisms (i.e., RMNCAH scorecard) for sustainability; (v) balance

[13] [http://www.tzonline.org/pdf/thetanzaniadevelopmentvision.pdf]
[14] [https://d2s5011zf9ka1j.cloudfront.net/sites/default/files/2021-07/FYDP%20III%20English.pdf]
[15] [https://mitu.or.tz/wp-content/uploads/2021/07/Tanzania-Health-Sector-Strategic-Plan-V-17-06-2021-Final-signed.pdf]

between ambition ("stretch") and feasibility ("realism"); and (vi) a reasonably even distribution of disbursements.

Figure 2. Disbursement-Linked Indicators



Rating of Overall Relevance

Relevance: High

The operation's overall relevance is deemed high, to reflect the high relevance of both its PDO and the DLIs.

B. ACHIEVEMENT OF PDOs (EFFICACY)

Assessment of Achievement of Each Objective or Outcome

Achievement of Key Outcome Indicators

31. The results demonstrate that the PforR contributed to a significant expansion in coverage for all MNCH dimensions of care, including ANC, delivery, and post-natal care, as well as reproductive health services and nutrition. Besides institutional deliveries, significant scale-up of coverage was observed in the proportion of pregnant women attending at least four ANC visits and/or receiving IPT2 as well as children receiving vitamin A supplementation. Four out of the five PDOIs were achieved, of which three surpassed the end target. Only the PDOI on the star rating assessment was not achieved. The main outcomes resulting from this PforR operation is summarized as Table 5.[16]

Table 5. Achievement of PDOIs

PDO -To improve the quality of PHC services nationwide in the Recipient's territory with a focus on MNCH services			
	Baseline	**Revised End Target**	**Actual Value**
Quality of MNCH services at the facility level			
PDOI 1. PHC facilities with 3- Star Ratings and Above. *Not achieved*.	0%	30%	19%
Antenatal Care			

[16] The thresholds used are as follows: Surpassed/Exceeded: 100%+; Achieved/Substantially: 80%+; Partially Achieved: 65%-79%; and Not Achieved: Less than 64%.

PDOI 2. Pregnant women attending 4 or more ante-natal care (ANC) visits. *Exceeded*. • In addition, more pregnant women are starting ANC earlier, with percentage of pregnant women receiving ANC within the first 12 weeks of pregnancy increasing from 14 to 38 percent between 2015 and 2020.	41.20%	68%	90%
PDOI 4. ANC attendees receiving at least 2 doses of intermittent preventive treatment (IPT2) for malaria. *Substantially Achieved.*	42.52%	80%	79%
Institutional Deliveries			
PDOI 3. Institutional deliveries. *Exceeded.* • Skilled birth attendance exhibited a similar performance, increasing from 58 to 79 percent between 2015 and 2020. • The percentage of C-sections increased from 6.3 in 2015 to 10 percent in 2020.	44.72%	70%	83%
Nutrition			
PDOI 5 – Proportion of children 12-59 months receiving at least one dose of Vitamin A during the previous year. *Exceeded.* • In addition, the percentage of ANC attendees receiving adequate quantity of Iron and Folate tablets until the next ANC visit increased from 50.2 to 75 percent between 2015 and 2020, exceeded the original target (65 percent) but below the revised one (79 percent).	51%	90%	100%

32. *Star Rating Assessment* - The PforR supported the implementation of a "home-grown" assessment ("Star Rating") of all PHC facilities in the country (public, private and faith-based). The objective of the assessment was to provide the foundation for a nationwide assessment of service delivery of health care facilities. In addition, results from the assessment provided inputs for the preparation of quality improvement plans for individual facilities. The first round of the Star Rating assessment (baseline) in 2015-2016 covered a total of 6,993 health care facilities (i.e., dispensaries, health centers and hospitals); and the second round assessed a total of 7,289 health care facilities in 2017-2018. In the first round, almost one third of all PHC facilities were rated 0-star and only 2 percent scored 3 stars. However, there was a marked improvement between the first and second rounds, with 19 percent of health facilities assessed scoring three stars and above in 2017/18. Unfortunately, by the operation's closing date, the third round of assessments had not yet been completed due to (a) delays with releasing necessary funds, (b) transfer of the key staff overseeing the initiative, and (c) delays with the revision of the Start Rating tool. The original tool was manual, complex, and resource intensive. The achievement under PDOI 1 captured in this ICR is thus based on the 2017-2018 assessment, which is well below the anticipated targets (2018 intermediate target of 25 percent and 2020 revised end target of 30 percent). The government is carrying out the third round of the Star Rating Assessment; however, it still unclear when the exercise will be completed, and the results released.

33. Besides the PDO indicators, the program tracked additional indicators during the program period to assess LGA performance. As noted below, their achievements substantiate the PDOI results.

- **Post-natal care (PNC)**. Seventy-four percent of the women, including those who delivered at home, attending PNC within 48 hours after delivery and 51 percent within 3-7 days in 2020 compared to 41 and 26 percent, respectively, in 2015. Also, the percentage of newborns, including those who were delivered at home, that

received PNC within 48 hours after delivery increased from 40 to 72 percent between 2015 and 2020, and from 26 to 55 percent for newborns receiving it within 3-7 days.

- **Reproductive health**. The percentage of women of reproductive age using modern family planning methods increased from 37.3 in 2015 to 41.6 percent between 2015 and 2020, slightly below the original target and above the revised one (42 and 40 percent, respectively).
- **Others**. Outpatient visits and hospital admissions per capita increased from 0.73 to 1.1 between 2014 and 2019, to subsequently decrease to 0.76 in 2020, most likely due to the COVID-19 pandemic and fear of transmission. Evidence also points to improved management of birth complications due to expanded provision of emergency obstetric care services with 304 health facilities refurbished.

Achievement of IRIs by Results Areas

34. The PforR supported a multi-pronged approach to improve the quality of PHC, with a focus on MNCH. As noted earlier, actions under the PforR were organized under six Result Areas to address the main bottlenecks at the various levels of Tanzania's health system. The PforR made a substantial contribution to scaling up Direct Health Financing Facility (DHFF) countrywide, adoption of the performance-based payment framework under the DHFF, scaling up emergency obstetric care, and strengthening management capacity at the LGAs and health facilities. Overall, the PforR achieved or surpassed 12 out of 16 IRIs with significant progress made in areas such as improvements in the supply of tracer medicines and expanded CEmONC functional capacity, among others. The main results under each RA are summarized in Table 6.

Table 6. Achievement of Intermediate Results Indicators by Results Area

Intermediate Results			
Results Area 1: Health financing and public financing management	**Baseline**	**Revised End Target**	**Actual Value**
This RA aimed to address low government spending on health, poor public FM, and incomplete fiscal decentralization. As opposed to increasing, the share of health in the total government budget experienced a reduction. However, transparency in the use of health funds increased during the operation's lifetime, with the totality of MoHCDGEC/PORALG spending now being annually audited and a larger proportion of external audit reports of CHMTs with unqualified opinions. In addition, the implementation of the RBF program in nine regions paved the way for the implementation of direct transfers of funds to health care facilities under the DHFF.			
IRI 1 – Share of health in total government budget.[17] ***Not Achieved.***	8.5%	9.75%	7.0%
IRI 2 – Councils with unqualified opinion in the annual external audit report. ***Surpassed.***	80%	92%	95%
Other Indicator - The percentage of MoHCDGEC/PORALG expenditure supported in their annual audit increased from 92 percent to 100 percent between 2015 and 2020, in line with the 100 percent target. In addition, the percentage of health care facilities with bank accounts opened according to the guidelines from the MOFP Accountant General increased from 35 percent to 100 percent between 2015 and 2020, in line with the target (100 percent). These indicators were tracked during the verification exercise to assess integrity of the financial management system.			
Results Area 2: Performance management			

[17] The indicator "share of health in total government budget' was outside the influence of the Program. It was never achieved and in hindsight may not have been a realistic indicator for the Program.

This RA aimed to address low quality of MNCH services at the facility levels by introducing performance-based payments through the DHFF and simultaneously implementing two newly established programs: RBF and the Star-Rating assessment. The performance-based approach through the DHFF was adopted and scaled up countrywide. The RBF program was implemented in nine regions that were lagging in MNCH performance indicators. As noted earlier, the third Start-Rating assessment was not completed, and the delays in RBF payments to health facilities undermined its effectiveness.			
IRI 3 – Completion of "Star rating" assessment of PHC facilities as per the two-year cycle. ***Not Achieved*.**	0%	50%	0%
IRI 4 – RBF facilities receiving timely RBF payment on the basis of verified results every quarter.[18] ***Not Achieved***.	0%	100%	0%
IRI 5 – LGAs with functional Council Health Service Boards. ***Fully achieved.***	86.3%	100%	100%
Results Area 3: Human resources for health			
This RA aimed to address the shortage and uneven distribution of skilled HRH. Initial efforts at improving the staffing of health care facilities in nine critical regions were thwarted by a national hiring freeze and the dismissal of staff lacking the necessary certificates. Moreover, it was also determined that the issuance of PHC employment permits for these critical regions was outside the MoHCDGEC's authority. The MoHCDGEC and PORALG eventually received an initial permit to hire roughly 8,000 health workers and, in response to the persistent staff shortage, an additional 2,726 permits were issued to recruit staff with priority given to newly refurbished facilities. In addition, PORALG, with support from the Benjamin Mkapa Foundation, has recently recruited 502 various cadres on a two-year contract with the plan to later absorb them into the government system. While the HRH shortage somewhat diminished during the operation's lifetime, ensuring a continuous, evenly distributed supply of skilled HRH remains critical. Based on the 2019 Annual Health Sector Performance Profile, Tanzania still faces a significant staffing shortage (52 percent), most pronounced at the dispensary level with an overall shortage of 69 percent.			
IRI 6 – *Dropped:* Annual employment permits for PHC given to the 9 critical regions **IRI 7–** Dispensaries with skilled HRH. ***Substantially achieved.***	91%	100%	99.6%
Results Area 4: Supply chain management			
This RA aimed to address weaknesses in the supply chain management for health commodities, leading to lack of essential medicines in PHC facilities. Key issues were addressed along the supply chain by introducing new governance and accountability mechanisms; developing a new finance and business model for the MSD; engaging private sector in procurement and distribution; and utilizing ICT to improve inventory management and stock-outs reporting.			
IRI 8 – Health facilities with continuous availability of the tracer medicines in the past year based on MoHCDGEC medicine list. ***Surpassed***	30.6%	80%	89.4%
Results Area 5: MNCH Continuum			
This RA aimed to improve the coverage and quality of MNCH along the continuum of care by expanding the BEmONC capacity among dispensaries and health center; expanding CEmONC functional capacity in selected hospitals and health centers; strengthening the satellite blood banks which serve facilities with CEmONC. Five regions with poor performance on maternal and neonatal mortality indicators received priority focus. A total of 304 facilities were refurbished through the HBF, of which 296 were completed and 238 are providing emergency obstetric care with 160 carrying out C-sections. While there has been improvement in functionality, 58 completed facilities are still unable to provide emergency obstetric care due to lack of staff, medical equipment, and utilities (water and power). The deployment of about 5,000 staff to refurbished facilities coupled with training in			

[18] RBF facilities were meant to be paid 28 days after confirmation of verified results. This however was never achieved for the entire program duration due to chronic delays.

emergency obstetric and neonatal care was critical in expanding the capacity to provide emergency obstetric care. The improvement in the MNCH continuum has positively affected the management of birth complications through CEmONC services. The Program took an important step in this regard by supporting the upgrade of health centers to meet CEmONC standards, including blood transfusion services to address the main course for maternal deaths, which is post-partum hemorrhage. At the same time, training was provided to specific cadres (e.g., nurse anesthetists) to ensure that the CEmONC services were functional. In addition to reducing travelling times for pregnant women and decongesting the number of complicated cases at hospitals, the expanded CEmONC functional capacity has contributed to an increase in C-section deliveries, from 6.3 to 10 percent between 2015 and 2020, which is within the 10 to 15 percent range indicated by the World Health Organization.			
IRI 9 – Health facilities with functional CEmOC. ***Fully achieved.***	79	160	160
Result Area 6: M&E, Supervision and Capacity Building			
This RA aimed to address M&E and supervision as well as the structural capacity constraints in Tanzania's health sector. The PforR provided incentives to LGAs to enhance their data reporting practices as well as to RHMTs to increase their supervision to LGAs, including the performance of data-quality audits. This RA also supported the implementation of the GOT's comprehensive five-year capacity building program at all levels of the health system, which was jointly financed by the GOT and various DPs through parallel financing. Results were in line with expectations at the regional level, with RHMT routinely conducting supervision visits and data-quality audits at the LGA level. While the level of data completeness at the LGA has increased in line with expectations, data verification conducted by the Internal Auditor General indicates that there is still a large rate of errors in the DHIS. Regarding capacity building, the plan for capacity building was concluded late and its implementation remained slow through the operation's lifetime.			
IRI 10 – Completeness of quarterly HMIS data entered in DHIS by LGA (by the end of month after quarter ends). ***Surpassed***	89.5%	96%	97%
IRI 11 – RHMT's required biannual data quality audits (DQA) for LGAs that meets national DQA standards. ***Surpassed***	0%	80%	91%
IRI 12 – RHMTs conduct quarterly supportive supervision visits for the LGAs that meets national supervision standards and is reported in DHIS2. ***Substantially achieved***	0%	100%	93%
IRI 13 – Completion of annual capacity building activities compared to agreed annual plans. ***Substantially achieved***	0%	100%	81%
Corporate Results Indicators			
IRI 14 – People who have received essential health, nutrition and population services. ***Surpassed.***	0	30,000,000	37,435,355
IRI 15 – Number of children immunized. ***Surpassed.***	0	10,000,000	10,935,355
IRI 16 - Number of women and children who have received basic nutrition services. ***Surpassed.***	0	10,000,000	19,500,000
IRI 17 - Number of deliveries attended by skilled health personnel. ***Partially achieved.***	0	10,000,000	7,000,000

Achievement of DLIs

35. The achievement of DLIs is summarized in Table 7. Overall, the program was able to disburse 91% of the total planned DLI financing. DLI 3 and 7 substantially disbursed their allocations. For DLI 3 the progress was less than expected largely due to delays with making payments to the health facilities. Similarly, some activities under DLI 7 were not implemented due to delays with fund releases. (For the detailed assessment of the achievement of DLIs, see

Annex 5 - Achievement of DLIs.)

Table 7. DLI Achievement

Disbursement-Linked Indicators (DLIs)	Revised Allocation (US$ million)	Actual Disbursed (US$ million)	% Disbursed	DLR Status
DLI 1. Recipient has completed all foundational activities	35	35	100%	All DLRs achieved
DLI 2. Recipient has achieved all the Program annual results in institutional strengthening at all levels (national, regional, LGA and facilities)	65	60	92%	Achieved 4 out of 6 DLRs
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	65.2*	54	83%	Substantially achieved
DLI 4. LGAs have improved annual maternal, neonatal and child health service delivery and quality as measured by the LGA Balance Score Card	80.5	75	94%	Achieved 11 out of the 12 DLRs
DLI 5. Regions have improved annual performance in supporting PHC services as measured by regional Balance Score Card	3.1	3	97%	Achieved all the 2 DLRs
DLI 6. MOHCDGEC and PORALG have improved annual PHC service performance as measured by the national Balance Score Card[19]	6.4	6	94%	Achieved 4 out 5 DLRs
DLI 7. Completion of annual capacity building activities at all levels	15	12	80%	Substantially Achieved
Total	270.1**	245	91%	

*The amount was revised from US$81 million after USAID reduced its funding.
**The revision of DLI3 allocation reduced the total from US$286 million to US$270.1 million.

36. RBF Program - The RBF program provided results-based financing payments to dispensaries, health centers and district hospitals as incentives for improving the quantity and quality of PHC services, MNCH and nutrition in particular.20 As originally envisioned, it provided quarterly RBF payments directly to PHC facilities according to their levels of achievement with respect to a set of performance indicators (outputs adjusted by a quality score). Facilities were given considerable autonomy in the use of RBF funds, including the allocation of up to 25 percent for performance-based bonuses to facility staff and community health workers. To enhance accountability, reported achievements were subject to independent verification, with quarterly verification visits to all health facilities and incentives for accurate reporting. Phase 1 of the RBF rollout included 1,936 facilities in nine regions, including two regions with USAID support. While early results were encouraging, they were not sustained due to delays and interruptions in RBF payments to health facilities undermined the program's effectiveness. While the MoHCDGEC and PORALG submitted the required verified reports to the MOFP, RBF payments to the health facilities were not made. The underlying reason for the challenges with RBF payments was the lack of commitment to the RBF program and change in financing priority for the government.

[19] The DLR on LGA receiving CHF matching funds was dropped after government changed the procedure for matching the grants.
[20] The RBF component was partially financed by the Power of Nutrition Trust Fund to improve performance on selected nutrition indicators (e.g., vitamin A, community health workers, deworming).

Rating of Overall Efficacy

Rating: Substantial

37. The operation's impact in terms of improving the quality of PHC services, MNCH in particular, is deemed substantial. Four of the five PDO indicators were achieved, and actions implemented under the six RAs helped address significant bottlenecks at the national, regional and local levels. This, in turn, has positively impacted the overall performance of the country's health system, as reflected mainly by the significant expansion of coverage of MNCH services. The majority of DLRs were met with over 90% disbursement against DLIs.

C. JUSTIFICATION OF OVERALL OUTCOME RATING

Rating: Moderately Satisfactory

38. Overall, the operation's outcome is rated as Moderately Satisfactory to reflect its High relevance and Substantial efficacy. The operation had noteworthy achievements in enhancing the overall adequacy of MNCH and nutrition services, mainly in terms of timeliness and sufficiency. Despite the government's inability to conduct last round of star rating assessment in 2021, the project contributed to improving quality of health services as demonstrated by the increase in the number of health centers meeting the standards for obstetric emergency care (from 74 to 160), percentage of pregnant women attending 4 or more ANC visits (from 41% to 90%), and the percentage of PHC facilities with continuous availability of 30 essential drugs and supplies over a three-month period (from 30% to 89%).

D. OTHER OUTCOMES AND IMPACTS

Gender

39. By design, the Program had a strong focus on gender, with maternal health being one of its centerpieces to tackle the gender gap in accessing life-saving services as demonstrated by high maternal mortality. At current levels of fertility and mortality, 1 in 33 women will die during pregnancy, at childbirth, or during the 2 months after giving birth (DHS 2015/16). Progress on the provision of health care services for women was closely monitored under the PRF, with three out of the five PDOIs focusing on ANC care and institutional deliveries. Particularly noteworthy were the results in the capacity to manage birth complications through CEmONC services, including an increase in the number of health facilities that are providing caesarian section from 219 in 2015 to 377 in 2020--equivalent to a 72 percent increase.

Poverty Reduction and Shared Prosperity

40. Based on evidence from other projects supporting the provision of similar health services, the operation had the potential of contributing to decreasing the incidence of infant mortality and low birth weight. Likewise, nutrition services provided under the operation can be expected to have both short-term and long-term positive impacts on children's growth and development, immune status, cognitive function and learning ability and overall health. Finally, this program helped address issues related to high maternal morbidity and barriers to accessing reproductive health care, which can adversely affect women's health and hinder their economic opportunities.

Institutional Strengthening and Development

41. In addition to the specific achievements in terms of institutional development under the six RA described above, this operation helped set up the foundations for the future development of a national health insurance system, one of the medium-term policy objectives in the health sector. Specifically, the implementation of RBF in nine regions served as a successful proof of concept for the decentralization of health financing, laying the foundations for the implementation of the DFF in the entire country. Likewise, the Star Rating assessment was an important step toward ensuring that health facilities across the country met minimum quality standards. Having in place mechanisms for results-based financing at the facility level and quality assurance provides a solid foundation for the development of a national health insurance system. Finally, embedding nutrition services into an operation with a focus on MNCH was an innovation in the context of Tanzania, as most donors support them as standalone programs. The inclusion of Tanzania Food and Nutrition Centre, the use of PforR funds to purchase nutrition supplements and joint missions contributed toward the integration of these normally compartmentalized programs.

Unanticipated Impacts

42. The current COVID-19 pandemic did not spare Tanzania. The first case was confirmed on March 16, 2020, and as of April 29, 2020 (when official reporting of COVID-19 cases was stopped), a total of 509 cases, with 18 deaths and 167 known recovered cases had been reported. Up to program closing, Tanzania experienced three waves of COVID-19 transmission. Compared to the countries in the region, Tanzania did not impose a strict lockdown, nor enforce strict adherence to social distancing measures and wearing of masks. Due to lack of official data, the actual extent of the impact of COVID-19 on the health sector is unknown. Anecdotal evidence however does suggest COVID-19 disrupted access to, and provision of essential health services, especially for reproductive, maternal and child health care, as well as for the major communicable diseases.

43. Tanzania had the opportunity to strengthen its health response and prioritize delivery of essential health services. Evidence worldwide indicates that a well-functioning health care system is a critical determinant of a country's response capacity to the pandemic. The operation as part of the HBF contributed funding towards the COVID-19 response but resources were not utilized upon the Government’s declaration that the country was COVID-free. While at program closing, regular COVID-19 data was still not being shared, the situation has since changed. The government strategy has been comprehensively revised in line with global standards and now embraces COVID-19 vaccination and regular reporting of COVID-19 data.

III. KEY FACTORS THAT AFFECTED IMPLEMENTATION AND OUTCOME

A. KEY FACTORS DURING PREPARATION

44. The Program design exhibited both strengths and weaknesses, which are summarized below.

45. *Strengths* – The operation had strong ownership on the part of the MoHCDGEC, as it mirrored its own bold and ambitious reform agenda as reflected in the BRN in Health Program. It was also in full alignment with two of the four objectives set out in the Bank's Country Assistance Strategy FY2012-15 for Tanzania (i.e., strengthening human capital and safety nets to, in turn, improve access to and quality of health service; and promoting accountability and governance, which is a cross-cutting objective to improve accountability and efficiency of public management). Its design benefited from a solid diagnosis of the main bottlenecks affecting the quality of PHC delivery and a clear and

logical Results Chain. The operation capitalized on the existing HBF architecture to facilitate the pooling of funds with other DPs. Likewise, the adoption of the PforR instrument ensured the operation's strong focus on results, with DLIs and DLRs providing financial incentives for addressing the various bottlenecks at the national, regional, district and facility levels. Finally, the PforR was fully integrated within the HBF and shared results, as the funds for the DLIs were channeled through the HBF, apart from DLIs 3 (RBF) and 7 (capacity building). One of the HBF partners, Canada, adopted the PforR results to disburse their contribution to government.

46. *Weaknesses* - The Program was inherently complex, involving many actors at all levels of the health system (i.e., central, regional, district and health care facility). Although this risk was somewhat offset by the strong ownership that the GoT exhibited at preparation for the Star-Rating assessment and RBF, the simultaneous introduction of these two new initiatives added to the operation's complex design. In addition, the DLI framework was too complex with a large number of DLRs, different formulas in different time periods, different reporting and verification frequencies. This was particularly challenging given that it was the first time the PforR instrument was being used in the health sector. While the adoption of the PforR instrument enhanced the focus on results, it also had some downsides, as it introduced uncertainty with regard to the actual level of financial assistance to be provided. Finally, while the PDO focused on quality of MNCH services, PDOIs focused primarily on coverage.

B. KEY FACTORS DURING IMPLEMENTATION

Outside the control of the Government

47. COVID-*19 pandemic* – Given that the operation was in its later stages of implementation, COVID-19 did not hinder the completion of program activities, particularly since field verification activities for the RBF had already been completed. However, in line with what has been observed in countries around the world, the utilization rates of health services supported under the Program dropped in 2020. This was particularly the case for preventive health services such as the ones supported under this operation. Nonetheless, the Program achieved or exceeded all coverage-related indicators.

48. *Stable macroeconomic environment* – Until early 2020, the Program was implemented under relatively stable macroeconomic conditions, with GDP growth fluctuating between 6 and 7 percent between 2015 and 2019. The country's gross national income (GNI) per capita reached US$1,080 in 2019, triggering Tanzania's formal graduation from low-income to lower-middle-income country status. In 2020, however, Tanzania's economy contracted sharply due to the COVID-19 pandemic, with GDP growth dropping to about 2 percent. Although the government did not impose stringent mobility restrictions, the pandemic prompted firms and consumers to adopt precautionary behaviors, hindering domestic economic activity. Given the overall macroeconomic stability until 2020, the delays in RBF payments that were experienced throughout the operation's lifetime cannot be attributed to budgetary constraints.

Within the control of the Government

49. *Political economy factors* – Changes in government priorities and senior officials in MoHCDGEC, PORALG and

MOFP adversely impacted the technical and policy dialogue related to the Program. In general, strengthening of infrastructure was conferred increased priority by the government. In addition, the prioritization of civil works within the health sector posed a detriment to RBF and the payment of bonuses. The turnover of senior officials at the MoHCDGEC during the operation's lifetime made it very difficult to maintain the technical and policy dialogue, particularly from 2018 onwards.[21]

50. *Delays in RBF payments* - The flow of *RBF* payments to health care facilities was highly inconsistent since early stages of implementation, with delays going back to early 2017. RBF payments were first delayed, subsequently resumed and halted again, with already verified RBF payments corresponding to Q4 2018 onwards being paid only in 2021. The disruptions in RBF payments severely undermined the effectiveness of the RBF program, as they demotivated health care facilities and limited their capacity to improve performance. In addition, these delays contributed to low disbursements under the DLI 3 and the underutilization of USAID funds. The interruption in RBF payments was the result of the MOFP's decisions to, initially, incorporate additional reporting requirements.[22] While MoHCDGEC and PORALG complied and availed the required reports, RBF payments to the health facilities were not made. Partial RBF payments to the health facilities were made just before the program closing date.[23]

51. *Early results from RBF implementation were highly encouraging.* These included measurable increases in the RBF quality indicator (i.e., a composite indicator of eight sub-indicators) and data management (i.e., correctness and completeness), with the overall performance of RBF regions surpassing that of their non-RBF counterparts. The main factors affecting the enhanced performance of RBF facilities were the added technical support they received in the preparation and implementation of quality improvement plans, as well as financial incentives in the form of start-up funds and RBF payments, which facilities utilized to purchase supplies and undertake minor infrastructure upgrades as planned under their quality improvement plans. In addition to improving data quality and physical conditions, RBF payments served to incentivize facilities to innovate, with some of them undertaking strategies to proactively expand the demand for MNCH services through the creation of new community programs and providing incentives to pregnant women.

52. *Underutilization of funds* - Several factors contributed to the operation's low disbursements with the main one being the delays with RBF payments to the health facilities (DLI 3). Other factors were the consistent failure to achieve the DLRs on employment permits, share of the health budget and Star-Rating assessment. As shown in Annex 3, out of the initial envelope of US$306 million, only US$245 million was disbursed (80.1 percent). Lowest levels of disbursement were for the Power of Nutrition TF (72.7 percent) and USAID TFs (22.1 percent). While the utilization of the PforR was successful in tying disbursements to actual results, it also made disbursements less predictable, affecting the Bank's and DPs' financial programming.

53. *Direct Health Financing Facility (DHFF)* - Prior to 2016, health funds were transferred to LGAs, which, in turn, provided health facilities with service-delivery inputs based on annual plans. In 2016, significant innovations were

[21] Since 2018, the MoHCDGEC has had four Permanent Secretaries.
[22] The MOFP introduced reporting requirements (i.e., the submission of implementation reports from health facilities) that were not originally envisioned or included in the PAD. This decision created operational difficulties for PORALG, responsible for coordination, as the Health Information Management System was not automated to collate the information.
[23] RBF reimbursements to government were made upon submission of a withdrawal application with confirmation of payments to the health facilities. Since government only made a partial payment, the full verified amount was not reimbursed.

introduced in health financing in the nine regions implementing the RBF program, when RBF funds (i.e., financial resources rather than in-kind support) began to be transferred directly to health facilities based on results rather than on budgetary allocations. In 2018, the GOT began transferring HBF funds under DHFF, adopting some of the key features of RBF: HBF funds began flowing directly to health facilities rather than to LGAs, with facilities having increased autonomy in planning and budgeting.[24] However, the DHFF budget protocol is more restrictive than for RBF (e.g., DHFF cannot be used for capital investments or bonuses). Early success in the implementation of RBF provided important lessons and laid the ground for the implementation of DFF countrywide.

Within the control of the Implementing Agency

54. *Initial lack of understanding of PforR* – Given that this was the first experience with this financing instrument in the sector, initially there was a lack of understanding within the MoHCDGEC (i.e., MNCH, nutrition, reproductive health units/sections) as well as at the sub-national level of the PforR mechanics and how to access funds. The Bank Task Team responded by proactively engaging with government agencies, DPs and sub-national entities, conducting PforR information sessions, including as part of other regular events (e.g., annual meetings of the Regional and District Medical Officers). Operations Clinics and other forums were also useful to overcome this bottleneck. In retrospect, a simpler DLI disbursement scheme (fewer DLRs; less variation in disbursement formulas; homogeneous payment schemes for RBF and HBF) may have facilitated understanding among government counterparts.

55. *Final Star-Rating assessment* – As mentioned earlier, the improvements in quality between the first and second rounds of Star Ratings assessments were highly encouraging, and even though budget and plans were already in place, the third round of assessments was delayed. While the reasons for this delay were never made clear to the Bank, the approach was perceived as too time consuming, resource intensive and expensive. Management changes in the MoHCDGEC and the Project Implementation Unit may have also been contributing factors. The MoHCDGEC is presently reassessing the Star-Rating methodology and weighing alternative approaches to be conducted at the sub-national instead of national level. Finally, in view of the low general scores achieved during the first two rounds, the tool itself may have been ambitious and unrealistic given the context in Tanzania.

56. *Reputational costs* - For the MoHCDGEC, the halting of implementation of the Star-Rating assessment and the RBF programs creates additional hurdles for any future attempts to introduce other initiatives at the sub-national and facility levels. It also constitutes a significant loss of opportunity, particularly in view of the formidable efforts that went into the implementation of these initiatives (i.e., 1,936 facilities were implementing RBF in the nine regions and over 7,000 facilities were assessed twice as part of the Star-Rating assessment) and the promising results in the early stages of implementation.

IV. BANK PERFORMANCE, COMPLIANCE ISSUES, AND RISK TO DEVELOPMENT OUTCOME

[24] Mæstad, O. and Binyaruka, P. (2021), *Towards harmonized decentralized financing of health services in Tanzania*, Unpublished manuscript, 19 May 2021, Chr. Michelsen Institute and Ifakara Health Institute.

A. QUALITY OF MONITORING AND EVALUATION

M&E Design

57. The PRF's reliance on service delivery indicators was in large part due to the efforts made during preparation to adopt the GOT's own indicators as PDOIs, IRIs and DLIs and to use routine information systems to monitor them. Out of 19 indicators under the PRF, 12 were indicators under the HSSP IV and BRN in Health. Data for the indicators under the operation's PRF were generated based on government information systems, as follows: (i) DHIS, which includes information on service delivery by PHC facility; (ii) Logistics Management Information System, which includes information on supply chains management for health; (iii) Human Resource for Health Information System, which includes information on staffing; (iv) Planning and Reporting, which includes information on council health plans and their implementation; and (v) Integrated Financial Management Information System (IFMIS) which includes financial management by LGA. The first three information systems are maintained by MoHCDGEC, while the remaining two are maintained by PORALG and MOFP, respectively.

58. The operation's M&E design was effective in: (i) aligning the operation's M&E with that of the MoHCDGEC, (ii) increasing MoHCDGEC's ownership of the PRF and the DLIs; and (iii) strengthening MoHCDGEC's M&E systems and ensure their sustainability.

M&E Implementation

59. The original PRF was refined during the first year of implementation, when baselines and end-Program targets were recalibrated. Both the PRF and the DLIs were further fine-tuned under the 2020 restructuring, which introduced adjustments to better reflect their pertinence, results focus and operational efficiency (see Section 1.B).

60. The operation served to enhance the quality of the GOT's information systems. Specifically, the PforR provided support for DQAs for all LGAs at least twice a year to help improve the quality of DHIS. Incentives were provided under DLIs for: (i) LGAs to improve the completeness and timeliness of DHIS data; and (ii) RHMTs to conduct DQA for LGAs, using standardized protocols. In addition, there was also technical assistance (TA) provided in the form of training in data use and quality in February 2020.

61. Disbursements were made upon the presentation and verification of evidence of attainment of the Program's DLIs. The Internal Auditor General's office served as the independent verification agency responsible for carrying out annual verification for all DLIs according to well-defined protocols, including the verification of results of a randomly selected sample of health care facilities stratified by type of facility.

M&E Utilization

62. During implementation, DLIs helped hold stakeholders accountable and built a culture focusing on targets, reviewing results regularly, identifying lagging indicators and course-correcting to continuously improve their performance at all levels of the health system. This was noteworthy at the LGA level, where Program-related discussions, largely centered on facility refurbishment, gradually expanded to include also planning and budgeting of MNCH and nutrition activities and accountability in general. Some of the government teams were very proactive in using data to detect and address bottlenecks during implementation, such as the identification of low-performing councils by the nutrition team. In addition, the operation's PforR framework was used by Canada to tie their assistance to results in a coordinated manner.

Justification of Overall Rating of M&E Quality

Rating: Substantial

63. The overall quality of the operation's M&E system is deemed substantial, as it helped support and inform implementation, enhance DP coordination, and further strengthen government information systems in the health sector.

B. ENVIRONMENTAL, SOCIAL, AND FIDUCIARY COMPLIANCE

Environmental and Social (E&S) Systems

64. The Environmental and Social Systems Assessment (ESSA). The ESSA identified two main areas for action to ensure that the Program interventions are aligned with the core principles 1, 3 and 5 of OP/BP 9.00 applicable to the Program: health care waste management and social accountability. The ESSA used the Environmental and Social Management Framework prepared under the East Africa Public Health Laboratory Networking Project (P111556), Healthcare Waste Management Plans prepared under earlier World Bank financed projects and procedures as set out in the Healthcare Waste Management Policy Guidelines. Implementation of the ESSA started slowly, and prior to the MTR, Environmental and Social Safeguards rating was Moderately Unsatisfactory. The situation improved and the rating upgraded to Moderately Satisfactory with the appointment of a focal person, initiation of Environmental and Social Framework trainings, the revision of the necessary guidelines to include E&S safeguards as well as occupational health and safety measures, and the strengthening of the Grievance Redress Mechanism based on existing complaint handling systems in all the health facilities. Furthermore, the inclusion of the E&S measures during the annual verification exercise is noted to have contributed to strengthening the monitoring of ESSA implementation. Reports on the use of completed infrastructure indicated positive outcomes and significant positive environmental and social impacts in communities from enhanced service delivery, attributed to development and rehabilitation of infrastructure in the health facilities, and staff capacity building. For future projects, it would be important that implementation of ESSA is institutionalized and started much earlier.

Fiduciary Systems

65. The overall assessment of the Program with regards to fiduciary systems was for the most part Moderately Satisfactory. The program maintained appropriate financial management arrangements including staffing in

compliance with the legal covenants. Interim unaudited financial reports and external audit reports were submitted in a timely manner and found acceptable to the Bank. RBF payments to health facilities experienced considerable delays in the last two years; as a result, a large share was undisbursed/unutilized. Initially, fiduciary capacity was quite weak at LGAs and health facilities. This however improved with training, issuance of necessary guidelines, recruitment of 500 accountants by the LGAs and the role out of the electronic financial management reporting system countrywide. The annual procurement audits commenced in the third year of implementation and the value for money audit was conducted in the final year of program implementation. While the audits commenced much later, their findings were instrumental in strengthening capacity for fiduciary arrangements especially for procurement functions at the health facilities and facilitating the rollout of the DHF.

C. BANK PERFORMANCE

Quality at Entry

Rating: Satisfactory

66. The Bank's performance in ensuring quality at entry is considered moderately satisfactory. As noted earlier, the operation's overall design was relevant, technically sound and fully aligned with the strategic priorities of both the GOT and the Bank. Although ambitious, it sought to capitalize on a unique window of opportunity to support the reform of the country's health sector. The utilization the PforR approach, which was being used for the first time in the health sector in the Africa region, constituted an important innovation, serving as a precedent for other health operations in the region, such as in Benin and Ghana. The PforR approach helped ensure a focus on results as well as further alignment and coordination of DP assistance. The PRF and DLIs were consistent with the operation's conceptual design and operationally feasible, relying largely on existing government information systems.

Quality of Supervision

Rating: Moderately Satisfactory

67. Program supervision was in-depth and constant throughout the operation's lifetime, with regular supervision missions and findings being recorded in detailed Aide Memoires and Implementation Status and Results Reports (ISRs). There were three different Task Team Leaders, two of whom were based in the Bank's local office. Local presence facilitated communication with counterparts and DPs, which helped identify and address bottlenecks in a timely manner and strengthen coordination. Throughout implementation, the Task Team ensured the provision of additional TA as needed (e.g., development of the Star-Rating database, technical support to PORALG, among others). The MTR, which took place in 2018, was thorough and identified some technical bottlenecks in the PRF and DLIs, which were subsequently addressed in the operation's restructuring.

68. In addition to fulfilling its supervision responsibilities, the Bank team played a highly proactive TA role throughout the operation's lifetime, providing labor-intensive TA in substantive topics, operational aspects and the implementation of fiduciary, environmental and social safeguards. The Task Team also took the lead in DP coordination, actively coordinating and brokering with other partners and donors through various forums, such as the HBF Performance Committee, the Audit and Finance Sub-Committee and the Performance Monitoring Sub-

Committee.[25] Operations Clinics (and "mini-clinics"), critical for Program implementation and coordination, were organized and helped government agencies, non-government organizations and DPs agree on and coordinate key program implementation aspects (e.g., the implementation of the performance LGA scorecards; simplification of RBF procedures and indicators). Task Team members were actively engaged with government counterparts and other DPs. As an illustration, Task Team members not only engaged with MoHCDGEC and PORALG Nutrition Sections on the nutrition results and implementation challenges, but also with Tanzania's Food and Nutrition Centre and the United Nations Children's Fund (UNICEF) and other DPs in the area of nutrition through series of consultation meetings through the National Multisectoral Nutrition Action Plan framework, especially during the preparation of the Bank-financed Investing in the Early Years Project.[26] The Task Team also contributed to fostering policy dialogue with Tanzanian authorities, including active engagement in the MTR of the HSSP IV and the One Plan II, and the development of the HSSP V and the One Plan III, all of which took place during the operation's implementation period.

69. Finally, there was a delay (of about 18 months) in restructuring the Program, which was partly due to the lengthy internal discussions within the government. The World Bank team followed up with the government on a number of occasions. However, in retrospect, an earlier downgrading of the operation's ratings may have helped convey a strong message on the program's challenges and the need for urgency to resolve issues. With this shortcoming, the quality of supervision is considered moderately satisfactory.

Justification of Overall Rating of Bank Performance

Rating: Moderately Satisfactory

70. Overall, Bank performance is considered moderately satisfactory to reflect the satisfactory performance in ensuring quality at entry and moderately satisfactory performance during supervision.

D. RISK TO DEVELOPMENT OUTCOME

Rating: Substantial

71. Sustainability challenges are considered substantial as a result of: (i) declining government spending on health, low budget execution and dependence of external financing to sustain DDF payments to health care facilities; (ii) staffing challenges faced by the health sector as a whole; (iii) further improvements needed in quality and use of data; (iv) insufficient institutional capacity, particularly at the local and facility levels; and (v) other political and governance factors, in particular the increasingly centralized management of the budget and fund flow processes by the MOFP, that have resulted in increased delays in the release of funds to MoHCDGEC and PORALG, and, in many instances, releases not being made even when in the approved budget.

V. LESSONS AND RECOMMENDATIONS

72. **In addition to illustrating the importance of well-functioning fund pooling, this operation illustrates the significant potential of PforRs in fostering crucial coordination between government agencies and donors.** The implementation experience of this operation illustrates the effectiveness of results-linked disbursements in focusing

[25] The Basket Financing Committee provided oversight; the Audit and Finance Sub-Committee oversaw the financial accounts; and the Performance Monitoring Sub-Committee oversaw aspects of performance.
[26] Preparation of this project was eventually halted.

the efforts of government agencies on the achievement of results. Likewise, having a clearly defined, results-oriented framework of assistance at the sector level facilitates donor coordination. The inclusion of "Base Components" (i.e., unconditional allocation of resources) offers donors additional flexibility in cases where ensuring predictability of funding is an important consideration.

73. **Operations that support new, ambitious reform programs are vulnerable to changes in government priorities**. In the case of the RBF, the changes in government priorities severely undermined its effectiveness and sustainability.

74. **There are tradeoffs between a program's scope and its sustainability.** In retrospect, the Star Rating assessment initiative may have been overly ambitious, as the demands they imposed on the system in terms of technical and institutional capacity as well as financial resources proved to be unsustainable. A less resource-intense approach may have been more appropriate, helping reduce the sustainability risks**.**

75. **There is room to adapt the Star Rating assessment program to the existing resource envelope**. The robust results shown in only two rounds of Star-Rating assessments suggest that efforts should be made to continue it. A less taxing approach, such as more extended reassessment cycles (i.e., longer than two years) and a simplified assessment tool, could be explored to balance technical considerations and the resources required for its implementation (technical, institutional, and financial).

76. **Nutrition support can be effectively integrated into broader MNCH strengthening**. While support for nutrition services in Tanzania tends to be compartmentalized, the nutrition interventions within this operation benefited from (i) a strengthened primary health care system, which is essential for delivery of nutrition interventions; and (ii) improvements in maternal care and health outcomes that synergistically contribute to improved nutrition outcomes.

77. **Adequate and reliable financial incentives are one of the critical pillars needed to ensure the successful implementation of RBF mechanisms.** The systemic delays and eventual interruption of RBF payments to health care facilities (including payments that had already been verified) proved to be detrimental to its success.

78. **The economic losses associated with failed program implementation go beyond "sunk costs.**" Aborting the implementation of the RBF for non-program reasons despite highly encouraging early results has substantial efficiency implications. Economic loses included: (i) the significant amounts of resources (both financial as well as technical and institutional) that were invested; and (ii) the potentially sizable economic and social benefits that could have resulted from these programs.

79. **There are significant reputational costs associated with failed program implementation.** Without doubt, the disrupted implementation of the RBF program constituted an important missed opportunity, as reflected in the highly encouraging results obtained in early stages of implementation. However, there are also important reputational costs associated with the failed implementation including the loss of trust among stakeholders (i.e., health care facility, LGAs, regions) that are likely to negatively affect their willingness to earnestly participate in future initiatives.

80. **Increasing budgetary resources and ensuring timely releases are crucial for sustainable improvements in the health sector**. Chronic underfunding of the health sector, together with its substantial reliance on external funding

are not conducive to medium- and long-term improvements in the health status of Tanzania's people and the country's economic development. Timely release of already approved budgetary resources will enable the MoHCDGEC to implement its sector policies and programs with lasting impacts.

ANNEX 1. RESULTS FRAMEWORK, DISBURSEMENT LINKED INDICATORS, AND PROGRAM ACTION PLAN

Annex 1A. RESULTS FRAMEWORK

(i) PDO Indicators

Objective/Outcome: To improve the quality of PHC services nationwide with a focus on MNCH services

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
PHC facilities with 3- Star Ratings and Above	Percentage	0.00 25-Aug-2015	50.00 30-Jun-2020	30.00 30-Jan-2020	19.00 31-Dec-2018

Comments (achievements against targets):
Not achieved. The third round of assessment was not been conducted, the latest and final data is from 2018.

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Pregnant women attending 4 or more ante-natal care (ANC) visits	Percentage	41.20 25-Aug-2015	60.00 30-Jun-2020	68.00 30-Jan-2020	90.00 31-Dec-2020

Comments (achievements against targets):

Surpassed.

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
ANC attendees receiving at least 2 doses of intermittent preventive treatment (IPT2) for malaria	Percentage	42.52 25-Aug-2015	60.00 30-Jun-2020	80.00 30-Jan-2020	79.00 31-Dec-2020

Comments (achievements against targets):
Substantially Achieved

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Institutional deliveries	Percentage	44.72 25-Aug-2015	60.00 30-Jun-2020	70.00 30-Jun-2020	83.00 31-Dec-2020

Comments (achievements against targets):
Achieved

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Proportion of children 12-59 months receiving at least one dose of Vitamin A during the previous year	Percentage	51.00 25-Aug-2015	65.00 30-Jun-2020	90.00 30-Jan-2020	100.00 31-Dec-2020

Comments (achievements against targets):
Surpassed.

(ii) Intermediate Results Indicators

Results Area: Intermediate Results Indicators

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Share of health in total government budget	Percentage	8.50 25-Aug-2015	9.75 30-Jun-2020	9.75 30-Jan-2020	7.00 31-Dec-2020

Comments (achievements against targets):
Not Achieved.

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Councils with unqualified opinion in the annual external audit report	Percentage	80.00 25-Aug-2015	90.00 30-Jun-2020	92.00 30-Dec-2020	95.00 31-Dec-2020

Comments (achievements against targets):
Exceeded.

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Completion of “Star rating" assessment of PHC facilities as per the two-year cycle	Percentage	0.00 25-Aug-2015	50.00 30-Jun-2020	50.00 30-Jan-2020	0.00 31-Dec-2020

Comments (achievements against targets):
Not Achieved. The final cycle of assessment was not undertaken in time.

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
RBF facilities receiving timely RBF payment on the basis of verified results every quarter	Percentage	0.00 25-Aug-2015	95.00 30-Jun-2020	100.00 30-Jan-2020	0.00 31-Dec-2020

Comments (achievements against targets):
Not Achieved. Payments were consistently delayed and not made within the stipulated time.

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
LGAs with functional Council Health Service Boards	Percentage	86.30 25-Aug-2015	100.00 30-Jun-2020	100.00 30-Jan-2020	100.00 31-Dec-2020

Comments (achievements against targets):
Achieved.

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Health facilities with continuous availability of the tracer medicines in the past year based on MoHCDGEC medicine list	Percentage	30.60 25-Aug-2015	55.00 30-Jun-2020	80.00 30-Jan-2020	89.40 31-Dec-2020

Comments (achievements against targets):
Exceeded.

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Health facilities with functional CEmOC	Number	79.00 25-Aug-2015	104.00 30-Jun-2020	160.00 30-Jan-2020	160.00 31-Dec-2020

Comments (achievements against targets):
Achieved. By December 2020, 160 facilities were confirmed functional. Since the government continued with refurbishment, more facilities became functional by program closing, though the actual numbers could not be verified.

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Completeness of quarterly HMIS data entered in DHIS by LGA (by the end of month after quarter ends)	Percentage	89.50 25-Aug-2015	95.00 30-Jun-2020	96.00 30-Jan-2020	97.00 31-Dec-2020

Comments (achievements against targets):
Exceeded.

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised	Actual Achieved at Completion

				Target	
RHMT's required biannual data quality audits (DQA) for LGAs that meets national DQA standards	Percentage	0.00 25-Aug-2015	90.00 30-Jun-2020	80.00 30-Jan-2020	91.00 31-Dec-2020

Comments (achievements against targets):
Exceeded.

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Completion of annual capacity building activities compared to agreed annual plans	Percentage	0.00 25-Aug-2015	100.00 30-Jun-2020	100.00 30-Jan-2020	81.00 31-Dec-2020

Comments (achievements against targets):
Substantially achieved.

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Dispensaries with skilled HRH	Percentage	91.00	100.00	100.00	99.60

		25-Aug-2015	30-Jun-2020	30-Jan-2020	31-Dec-2020

Comments (achievements against targets):
Achieved.

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
RHMTs conduct quarterly supportive supervision visits for the LGAs that meets national supervision standards and is reported in DHIS2	Percentage	0.00 25-Aug-2015	90.00 30-Jun-2020	100.00 30-Jan-2020	93.00 31-Dec-2020

Comments (achievements against targets):
Exceeded.

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
People who have received essential health, nutrition, and population (HNP) services	Number	0.00 28-May-2015	30,000,000.00 30-Jun-2020		37,435,355.00 31-Dec-2020

Number of children immunized	Number	0.00 28-May-2015	10,000,000.00 30-Jun-2020		10,935,355.00 31-Dec-2020
Number of women and children who have received basic nutrition services	Number	0.00 28-May-2015	10,000,000.00 30-Jun-2020		19,500,000.00 31-Dec-2020
Number of deliveries attended by skilled health personnel	Number	0.00 28-May-2015	10,000,000.00 30-Jun-2020		7,000,000.00 31-Dec-2020

Comments (achievements against targets):
Exceeded. Previously, consultations rather than beneficiaries were captured for the basic nutrition services, and births attended by skilled health personnel were overestimated. The data are adjusted according to the achievement under the program.

ANNEX 1B. DISBURSEMENT LINKED INDICATORS

DLI 1: DLI 1: Recipient has completed foundational activities (Yes/No)

	Baseline	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	Total
Original values	No	Yes				Yes	Yes	
Actual values		Yes				Yes	Yes	

Allocated amount ($)		0.00	10,000,000.00	10,000,000.00	0.00	10,000,000.00	5,000,000.00	35,000,000.00
Disbursed amount ($)		0.00	10,000,000.00	4,000,000.00	0.00	15,000,000.00	6,000,000.00	35,000,000.00

Comments (achievements against targets):

Originally the activities were meant to be completed in the first two years. Following restructuring, DLR 7 on "Recipient has made refurbished health facilities CEmONC functional" was introduced for the last two years of the program. In total, the Program supported the functionality of 160 CEmONC facilities.

The rest of the DLRs were fully achieved. The original allocation was US$20 million. Additional allocation of US$15 million was added to the DLI1 during restructuring bringing the total to US$35 million.

DLI 2: DLI 2: Recipient has achieved Program annual results in institutional strengthening (Yes/No)

	Baseline	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	Total
Original values	No	Yes	Yes	Yes	Yes	Yes	Yes	
Actual values		Yes	Yes	Yes	No	Yes	Yes	
Allocated amount ($)		15,000,000.00	15,000,000.00	15,000,000.00	0.00	10,000,000.00	10,000,000.00	65,000,000.00
Disbursed amount ($)		15,000,000.00	15,000,000.00	15,000,000.00	0.00	10,000,000.00	10,000,000.00	65,000,000.00

Comments (achievements against targets):

All 6 DLRs were completed/achieved. The restructuring dropped “all or nothing” principle and introduced scalability. The original allocation was US$75 million, which was reduced to US$65 million with restructuring.

DETAILED ASSESSMENT: 1. Share of health in the total budget reached 7% against the target of 9.75% (NOT ACHIEVED). 2. Percentage of council whose annual comprehensive Council Health Plan (CCHP) passes the first round of assessment: ACHIEVED. Target: 95%; Actual: 95%. 3. Action Plans of Audits of PORALG and MOH received within 2 months of the official release of the controller and Auditor General (CAG) report: ACHIEVED. Action plans shared by both MOH and PORALG. 4. Percentage of PHC facilities with bank accounts opened according to guidelines from MOFP/CAG: ACHIEVED. Target: 100%; Actual: 100%. 5. Percentage of annual employment permits for PHC staff given to the 9 critical regions: Dropped following restructuring. 6. Percentage of completion of “Star Rating Assessment" of PHC facilities: Not Achieved. Target: 100%; Actual: 0%.

DLI 3: DLI 3: PHC facilities have improved maternal, neonatal and child health services delivery and quality as per verified results and received payments on that basis each quarter (Number)

	Baseline	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	Total
Original values	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
Actual values		0.00	0.00	0.00	0.00	0.00	0.00	
Allocated amount ($)		0.00	0.00	0.00	0.00	0.00	0.00	0.00
Disbursed amount ($)		0.00	10,000,000.00	11,000,000.00	20,000,000.00	15,300,000.00	6,200,000.00	62,500,000.00

Comments (achievements against targets):

The original allocation was US$106 million, which was reduced to US$81 million with restructuring. Because of failure to make RBF payments to the health facilities, the final total cumulative payments made for RBF was US$62.5 million. There were no annual allocations. Instead, RBF payments to health facilities were made against a performance-based formula.

DLI 4: DLI 4: LGAs have improved annual maternal, neonatal and child health services delivery and quality as measured by the LGA Balance Score Card . (Percentage)

	Baseline	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	Total
Original values	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
Actual values		80.00	0.00	0.00	0.00	0.00	0.00	
Allocated amount ($)		0.00	0.00	0.00	0.00	0.00	0.00	0.00
Disbursed amount ($)		16,000,000.00	14,000,000.00	14,000,000.00	16,000,000.00	10,500,000.00	10,000,000.00	80,500,000.00

Comments (achievements against targets):

Out of the 12 DLRs, 11 were achieved. The original allocation was US$82 million, which was reduced to US$80.5 million with restructuring. The annual allocations were not available given the nature of the DLR. The payments against the DLRs were based on a balanced score card.

DETAILED ASSESSMENT:

1. Percentage of pregnant women attending four or more antenatal care visits (ANC4): ACHIEVED: Target: 68%; Actual: 90%.

2. Proportion of mothers who received 2 doses of intermittent preventive treatment (IPT2) for malaria during last pregnancy: ACHIEVED. Target: 80%; Actual: 79%.

3. Percentage of institutional deliveries: ACHIEVED. Target: 70%; Actual: 83%.

4. Percentage of women of reproductive age (15-49 years) using modern family planning methods: ACHIEVED: Target: 40%; Actual: 41%

5. Percentage of pregnant women who receive adequate quantity of iron and folate tablets during their current ANC visit: ACHIEVED: Target: 79% Actual: 75%

6. Proportion of children 12-59 months receiving at least one dose of Vitamin A supplementation during the past year: ACHIEVED. Target: 100%; Actual: 100%.

7. Percent of PHC facilities with "3 stars" rating or higher: NOT ACHIEVED. Target: 35%; Actual: 19%.

8. Number and percentage of Public primary health facilities with at least one skilled staff: ACHIEVED. Target: 90% Actual: 98%

9. Percentage of PHC facilities with continuous availability of 10 tracer medicines (medicines, vaccines, medical devices) in the past year: ACHIEVED. Target: 80% Actual: 89%

10. Percentage of LGAs with functional Council Health Service Boards (meeting quarterly): ACHIEVED. Target: 100% Actual: 100%

11. Percentage of completeness of quarterly DHIS 2 entry by LGA (MTUHA phase one forms by Day 30 after the end of each quarter): ACHIEVED. Target: 96%; Actual: 97%

12. Percentage of LGAs with unqualified opinion in the external audit report. ACHIEVED. Target: 92%; Actual: 95%.

DLI 5: DLI 5: Regions have improved annual performance in supporting PHC services as measured by Regional Balance Score Card. (Percentage)

	Baseline	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	Total
Original values	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
Actual values		80.00	0.00	0.00	0.00	0.00	0.00	
Allocated amount ($)		0.00	0.00	0.00	0.00	0.00	0.00	0.00
Disbursed amount ($)		500,000.00	500,000.00	510,000.00	500,000.00	500,000.00	500,000.00	3,010,000.00

Comments (achievements against targets):

The original allocation was US$2.4 million, which was increased to US$3.1 million with restructuring. The annual allocations were not available given the nature of the DLR. The payments against the DLRs were based on a balanced score card. A cumulative total of US$3.01 million was disbursed against the DLI.

DLI 5 RESULTS: Achieved. DETAILED ASSESSMENT: 5.1. RHMTs required biannual data quality audits (DQA) for LGAs that meets national DQA standards. ACHIEVED. Target: 80%; Actual:91%. 5.2. RHMT's Required annual supportive supervision visits for LGAs that meets national supervision standards. ACHIEVED. Target: 100%; Actual 93%.

DLI 6: DLI 6: MoHCDGEC and PO-RALG have improved annual PHC service performance as measured by National Balance Scorecard (Percentage)

	Baseline	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	Total
Original values	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
Actual values		80.00	0.00	0.00	0.00	0.00	0.00	
Allocated amount ($)		0.00	0.00	0.00	0.00	0.00	0.00	0.00
Disbursed amount ($)		1,100,000.00	1,100,000.00	1,200,000.00	1,400,000.00	800,000.00	800,000.00	6,400,000.00

Comments (achievements against targets):

The original allocation was US$5.6 million, which was increased to US$6.4 million with restructuring. The annual allocations were not available given the nature of the DLR. The payments against the DLRs were based on a balanced score card. The entire allocation of US$6.4 million was disbursed.

Latest data is as of December 31, 2019. DETAILED ASSESSMENT: 6.1 Average of LGA performance score: NOT ACHIEVED. Target: 80%; Actual: 65%. 6.2. Average of Regional performance scores: ACHIEVED. Target: 80% Actual: 79%. 6.3. Percentage of unsupported expenditure in MOH/PORALG in their annual audit. ACHIEVED. Target: 0%; Actual: 0%. 6.4. Percentage of LGA's receiving CHF matching funds: NOT ACHIEVED. Target: 57%; Actual: 0%

DLI 7: DLI 7: Completion of annual capacity building activities at all levels as per the agreed annual plans. (Yes/No)								
	Baseline	**2015-16**	**2016-17**	**2017-18**	**2018-19**	**2019-20**	**2020-21**	**Total**
Original values	No	Yes						
Actual values		Yes						
Allocated amount ($)		0.00	0.00	0.00	0.00	0.00	0.00	0.00
Disbursed amount ($)		0.00	3,750,000.00	3,750,000.00	1,875,000.00	3,750,000.00	1,875,000.00	15,000,000.00
Comments (achievements against targets): The original allocation of US$15 million was not revised with restructuring.								

ANNEX 1C. PROGRAM ACTION PLAN

Action	**Timing**		**Achieved (Yes/No)**	**Completion Measurement**
Appoint Internal Auditor General as the independent verification entity.	Due Date	25-Nov-2015	Yes	IAG was Appointed as the verification agent.
Comments:				

Achieved.				
Submit basic reporting requirements for the sector as per the HBF requirement.	Due Date	30-Dec-2016	Yes	The necessary reports were submitted and discussed by the HBF Committee
Comments: Achieved. The performance and audit reports were submitted to the HBF sub committees.				
Implement the ESSA through the following: i) Inclusion of HCWM in the CCHP ii) Monitor and report on the implementation of HCWM activities in the CCHP.	Recurrent	Yearly	Yes	HCWM guidelines were prepared and training conducted
Comments: Partially Achieved. The Client appointed a Focal Person (July 2019) to oversee implementation of ESSA. General progress continued to remain slow. To strengthen the monitoring of ESSA, the Client in 2019 started using the verification agent to monitor implementation of the ESSA.				
Review the existing procurement vetting mechanisms with a view to reducing backlog	Due Date	30-Jan-2017	Yes	The process of procurement audits started late in 2019/20.
Comments:				

Partially Achieved. In order to strengthen procurement oversight, the verification agent (IAG) was asked to carry out annual procurement audits.				
Operationalize MSD system that issues out stock notices to facilities within one day as prescribed in the 2013 Public Procurement Regulation Act (Section 140) and the 2013 Public Procurement sub-regulations (Subsections 1 to 6).	Due Date	31-May-2018	Yes	MSD issued the permits though late.
Comments: Partially Achieved. The processes for issuing permits still delays.				
Conduct annual procurement audits of the program as well as Value for Money (VFM) audits by PPRA and CAG	Recurrent	Yearly	Yes	Submission of report
Comments: Achieved.				
Establish a PHCfoR Technical Committee and hold regular meetings to monitor implementation progress	Recurrent	Quarterly	Yes	Minutes of Meetings
Comments: Partially Achieved. Committee set up, but conducted few meetings.				

Promote the use of performance scorecard to enhance accountability	Recurrent	Yearly	Yes	Score Cards reports

Comments:

Achieved.

ANNEX 2. BANK LENDING AND IMPLEMENTATION SUPPORT/SUPERVISION

A. TASK TEAM MEMBERS

Name	Role
Preparation	
Peter Okwero	Task Team Leader(s)
Gisbert Joseph Kinyero	Procurement Specialist(s)
Vida Ndilanha Nkya	Financial Management Specialist
Kimberly Rachel Boer	Team Member
Liying Liang	Team Member
Neema Clarence Mkundi	Team Member
Caroline Martin Kingu	Team Member
Chiho Suzuki	Team Member
Jacob Omondi Obongo	Social Specialist
Imma Ismaily Killasama	Procurement Team
Mugambi Mugisha Mwendia	Team Member
Mariko Fukao	Team Member
Petronella Vergeer	Team Member
Lisa Shireen Saldanha	Team Member
Simon B. Chenjerani Chirwa	Procurement Team
Mariam Ally Juma	Team Member
Jane A. N. Kibbassa	Environmental Specialist
Phoebe M. Folger	Team Member

Son Nam Nguyen	Team Member
Eva K. Ngegba	Team Member
Evelyn Anna Kennedy	Team Member
Supervision/ICR	
Peter Okwero	Task Team Leader(s)
Gisbert Joseph Kinyero, Raymond Joseph Mbishi	Procurement Specialist(s)
Vida Ndilanha Nkya	Financial Management Specialist
Kimberly Rachel Boer	Team Member
Liying Liang	Team Member
Neema Clarence Mkundi	Team Member
Caroline Martin Kingu	Team Member
Chiho Suzuki	Team Member
Jacob Omondi Obongo	Social Specialist
Imma Ismaily Killasama	Procurement Team
Mugambi Mugisha Mwendia	Team Member
Petronella Vergeer	Team Member
Lisa Shireen Saldanha	Team Member
Grace Anselmo Mayala	Procurement Team
Mariam Ally Juma	Team Member
Jane A. N. Kibbassa	Environmental Specialist
Phoebe M. Folger	Team Member
Inaam Ul Haq	Team Member

B. STAFF TIME AND COST

Stage of Project Cycle	Staff Time and Cost	
	No. of staff weeks	US$ (including travel and consultant costs)
Preparation		
FY15	69.031	565,694.67
FY16	35.530	184,775.28
FY17	.765	3,455.35
Total	**105.33**	**753,925.30**
Supervision/ICR		
FY16	24.436	207,809.41
FY17	106.501	763,383.27
FY18	102.465	643,514.16
FY19	79.368	529,147.79
FY20	98.484	1,022,219.17
Total	**411.25**	**3,166,073.80**

ANNEX 3. PROGRAM EXPENDITURE SUMMARY

Source of Program Financing (US$)	Type of Co-Financing	Estimates at Appraisal	Actual Expenditures (Disbursement)		
			Actual	Percentage of Appraisal	Percentage of Actual
IDA	Credit	200	186.24	93.1%	76.0%
USAID	Pooled	46	10.18	22.1%	4.2%
Power of Nutrition TF	Pooled	20	14.54	72.7%	5.9%
GFF TFF	Pooled	40	34.04	85.1%	13.9%
Total		306	245.0	80.1%	100.0%

Note: USAID originally committed US$46 million, but only obligated US$10.18 million.

ANNEX 4. BORROWER'S COMMENTS

ANNEX 5. ACHIEVEMENT OF DISBURSEMENT-LINKED INDICATORS

Disbursement-Linked Indicators and Results		2014/2015	Targets		Achievement (Yr 6)		
		Baseline	Original (Yr 5)	Revised (Yr 6)	Actual Value	Original (%)	Revised (%)
DLI 1: Foundational Activities							
DLR 1.1	A 5-year Capacity Building Plan for the Program was developed and approved by the World Bank.	No	Yes		Yes	100%	
DLR 1.2	Data Quality Audit tools were prepared, field tested and disseminated in all 26 regions and 184 LGAs. These tools are being routinely utilized by RHMTs.	No	Yes		Yes	100%	
DLR 1.3	Financial Management Manual for HFs accounts was prepared by PORALG in 2015 and subsequently disseminated at the subnational level.	No	Yes		Yes	100%	
DLR 1.4	Baseline data (2014) was adjusted and targets for performance indicators were verified.	No	Yes		Yes	100%	
DLR 1.5	Geographical Position System (GPS) locations were prepared for 7,356 facilities including public, private and faith-based organizations.	No	Yes		Yes	100%	
DLR 1.6	RMNCAH-specific foundational activities						
a.	BEmONC and CEmONC assessment in the five BRN RMNCAH regions was completed in the first year of implementation. Reassessment was done as part of the Star-Rating Assessment.	No	Yes		Yes	100%	
b.	Eight out of the eight Health Centers in five BRN RMNCAH regions were verified to meet CEmONC standards.	No	Yes		Yes	100%	
c.	At least 70% of HFs in five BRN RMNCAH regions were verified to meet BEmONC standard under the second Star-Rating Assessment.	No	Yes		Yes	100%	
DLR 1.7	Health facilities with functional CEmOC	0	79	160	160	129%	129%
DLI 2: Institutional Strengthening Indicators							
DLR 2.1	**IRI 1.** Share of health in total government budget	8.5	9.75		7	55%	
DLR 2.2	**IRI 2 -** Councils with unqualified opinion in the annual external audit report	80	90	92	95	150%	125%
DLR 2.3	**IRI 3 -** Completion of “Star rating" assessment of PHC facilities as per the two-year cycle	0	50		0	0%	
DLR 2.4	Action Plans of audits by MoHCDGEC and PORALG received within two months of release by the Comptroller and Auditor General	0	100		100	100%	
DLR 2.5	Percentage of PHC facilities with bank accounts opened according to Guidelines from MoFP/Accountant General	7.6	100		100	100%	

DLR 2.6	Annual audits of procurement contracts		100		100	100%	
DLI 3: Performance of RBF Health Facilities							
DLI 3	RBF facilities have improved MNCH service delivery and quality as per verified results and received payments on that basis each quarter (US$ million)						
	- RBF payments made to health care facilities	0	100	81	54.3	54.3%	67.0%
DLI 4: LGA Performance Scorecard							
Part 1 - MNCH Service Delivery Outputs							
DLR 4.1	**PDOI 2 -** Pregnant women attending 4 or more ante-natal care (ANC) visits	41.2	60	68	90	260%	182%
DLR 4.2	**PDOI 4 -** ANC attendees receiving at least 2 doses of intermittent preventive treatment (IPT2) for malaria	42.52	60	80	79	209%	97%
DLR 4.3	Percent of ANC attendees receiving adequate quantity of Iron and Folate tablets until the next ANC visit	50.2	65	79	75	168%	86%
DLR 4.4	**PDOI 3 -** Percentage of Institutional deliveries	44.72	60	70	83	251%	151%
DLR 4.5	Percentage of women of reproductive age using modern family planning methods	37.3	42	40	41.6	91%	159%
DLR 4.6	**PDOI 5 -** Proportion of children 12-59 months receiving at least one dose of Vitamin A during the previous year	51	65	90	100	350%	126%
Part 2 - Improving Conditions for Quality of Care							
DLR 4.7	**PDOI 1 -** PHC facilities with 3- Star Ratings and Above	0	50	30	19	38%	63%
DLR 4.8	**IRI 7 -** Dispensaries with skilled HRH *	91	90	100	99.6		
DLR 4.9	**IRI 8 -** Health facilities with continuous availability of the tracer medicines in the past year based on MoHCDGEC medicine list	30.6	55	80	89.4	241%	119%
DLR 4.10	**IRI 5 -** LGAs with functional Council Health Service Boards	86.3	100		100	100%	
DLR 4.11	**IRI 10 -** Completeness of quarterly HMIS data entered in DHIS by LGA (by the end of month after quarter ends)	89.5	95	96	97	136%	159%
DLR 4.12	**IRI 2 -** Councils with unqualified opinion in the annual external audit report	80	90	92	95	150%	125%
DLI 5: Regional Performance Indicators							
DLR 5.1	**IRI 11 -** RHMT's required bi-annual data quality audits (DQA) for LGAs that meets national DQA standards	0	90	80	91	103%	116%
DLR 5.2	**IRI 12 -** RHMTs conduct quarterly supportive supervision visits for the LGAs that meets national supervision standards and is reported in DHIS2	0	90	100	93	101%	114%
DLI 6: National Performance Indicators							

DLR 6.1	Average LGA Performance Scores	35.5		64.8	66%
DLR 6.3	Average Regional Performance Scores	40		79	98%
DLR 6.4	Percentage of supported expenditure in MoHSW	92	100	100	100%
DLR 6.5	Percentage of supported expenditure in PORALG	92	100	100	100%
DLR 6.6	Percentage of LGAs receiving CHF matching funds	n.a.	57	0	0%
DLI 7: Capacity Building Activities					
DLI 7	Completion of annual institutional strengthening activities at all levels as per the agreed annual plans	0	100	81.0	90%

Note: In the case of DLRs that do not have a corresponding PRF indicator, data was derived from Table 15 (PAD) and ISR #12.

* Level of achievement cannot be determined as baseline is greater than the target.

** Undetermined due to changes in the corresponding program.