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Report No: 65577-TZ

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED CREDIT

IN THE AMOUNT OF SDR63.1 MILLION
(US$100 MILLION EQUIVALENT)

TO

THE UNITED REPUBLIC OF TANZANIA

FOR A

BASIC HEALTH SERVICES PROJECT

November 22, 2011

CURRENCY EQUIVALENTS

(Exchange Rate Effective October 31, 2011)

Currency Unit	=	Tanzanian Shilling (TZS)
TZS1,725	=	US$1
US$1.5848	=	SDR 1

FISCAL YEAR
July 1 – June 30

ABBREVIATIONS AND ACRONYMS

AAA	Analytic and Advisory Activities
AfDB	African Development Bank
AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante-Natal Care
APL	Adaptable Program Loan
ASDP	Agricultural Sector Development Program
BFC	Basket Financing Committee
BFSC	Basket Fund Steering Committee
CA	Consolidated Account
CAS	Country Assistance Strategy
CBG	Capacity Building Grants
CCHP	Comprehensive Council Health Plan
CDG	Council Development Grant
CHMT	Council Health Management Teams
CIDA	Canadian International Development Agency
CPAR	Country Procurement Assessment Report
CPR	Contraceptive Prevalence Rate
CQS	Consultancy Qualification Selection
CSSC	Christian Social Service Commission
DANIDA	Danish International Development Agency
D-by-D	Decentralization by Devolution
DFID	UK Department for International Development
DHIS	District Health Information System
DP	Development Partners
DPG-Health	Development Partners Group – Health
DPL	Development Policy Loan
EMOC	Emergency Obstetric Care Equipment
EMP	Environmental Management Project
EU	European Union
FBOs	Faith-Based Organizations

FBS	Fixed Budget Selection
FDI	Foreign Direct Investment
FMS	Financial Management System
FY	Fiscal Year
GDP	Gross Domestic Product
GEF	Global Environmental Facility
GF	Global Fund
GoT	Government of the United Republic of Tanzania
HBF	Health Basket Fund
HBS	Household Budget Survey
HCWM	Health Care Waste Management
HIV	Human Immune-Deficiency Virus
HMIS	Health Management Information System
HRH	Human Resources for Health
HSDP	Health Sector Development Program
HSRS	Health Sector Reform Secretariat
HSSP	Health Sector Strategic Plan
IBRD	International Bank for Reconstruction and Development
IC	Implementation Committee
ICB	International Competitive Bidding
ICT	Information and Communications Technology
IDA	International Development Association
IFAD	International Fund for Agricultural Development
IFMIS	Integrated Financial Management System
IFR	Interim Financial Report
IMCI	Integrated Management of Childhood Illness
IPSAS	International Public Sector Accounting Standards
IRR	Internal Rate of Return
JAHSR	Joint Annual Health Sector Review
JAST	Joint Assistance Strategy for Tanzania
JICA	Japan International Cooperation Agency
LCS	Least Cost Selection
LGAs	Local Government Authorities
LGDG	Local Government Development Grant
LGSP	Local Government Support Project
M & E	Monitoring and Evaluation
MDG	Millennium Development Goals
MESI	Monitoring and Evaluation Strengthening Initiative
MoF	Ministry of Finance
MoHSW	Ministry of Health and Social Welfare
MoU	Memorandum of Understanding
MOW	Ministry of Water
MR	Mortality Rate

MSD	Medical Stores Department
MTEF	Medium-Term Expenditure Framework
NAO	National Audit Office
NAP	National Action Plan
NATNETS	National Insecticide Treated Nets Strategy
NBS	National Bureau of Statistics
NCB	National Competitive Bidding
NHA	National Health Accounts
NHIF	National Health Insurance Fund
NPEHI	National Package of Essential Health Interventions
NPEHSWI	National Package of Essential Health and Social Welfare Interventions
NPV	Net Present Value
NSGRP	National Strategy for Growth and Reduction of Poverty (MKUKUTA)
OP	Out Patient
ORAF	Operational Risk Assessment Framework
P4H	Providing for Health
PAD	Project Appraisal Document
PDO	Project Development Objectives
PEFA	Public Expenditure and Financial Assessment
PEPFAR	President's Emergency Program for AIDS Relief
PFM	Public Financial Management
PFMRP	Public Financial Management Reform Program
PMI	President's Malaria Initiative
PMIS	Procurement Information Management System
PMO-RALG	Prime Minister's Office – Regional Administration and Local Government
PMU	Procurement Management Unit
PPA	Public Procurement Act
PPRA	Public Procurement Regulatory Authority
PRSP	Poverty Reduction Strategic Paper
PSO	Principal Supplies Officer
PST	Program Support Team
QBS	Quality Based Selection
QCBS	Quality and Cost Based Selection
RBF	Results Based Financing
RHMTs	Regional Health Management Teams
RS	Regional Secretariat
RWSS	Rural Water Supply and Sanitation
SC	Steering Committee
SDG	Service Delivery Grant
SIM	Sector Investment and Maintenance
SSS	Social Sectors Strategy
SWAp	Sector Wide Approach
TBD	To be decided

TC-SWAp	Technical Committee – Sector Wide Approach
TFR	Total Fertility Rate
THE	Total Health Expenditure
TOR	Terms of Reference
TSCP	Tanzania Strategic Cities Project
TSH	Tanzania Shillings
TZS	Tanzania Shillings
UN	United Nations
UNCDF	United Nations Capital Development Fund
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
US	United States
USAID	United States Agency for International Development
USG	United States Government
UWSS	Urban Water Supply and Sanitation
WB	World Bank
WSSP	Water Sector Support Program
YR	Year

Vice President:	Obiageli Katryn Ezekwesili
Country Director:	Mercy M. Tembon
Sector Director:	Ritva S. Reinikka
Sector Manager:	Jean-Jacques de St. Antoine
Task Team Leader:	Dominic S. Haazen

United Republic of Tanzania

Basic Health Services Project

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PAD DATA SHEET

United Republic of Tanzania
Basic Health Services Project

PROJECT APPRAISAL DOCUMENT

AFRICA Region
Health Nutrition and Population Unit

Date: November 18, 2011 Country Director: Mercy M. Tembon Sector Manager/Director: Jean-Jacques de St. Antoine / Ritva Reinikka Project ID: P125740 Lending Instrument: SIM Team Leader(s): Dominic S. Haazen	Sector(s): Health (80%), Sub-national government administration (20%) Theme(s): Health system performance (70%), Decentralization (30%) EA Category: B – Partial Assessment

Project Financing Data:

Proposed terms:

[ ] Loan [X] Credit [ ] Grant [ ] Guarantee [ ] Other:

Maturity of 40 years including a grace period of ten years.

Source	Total Amount (US$M)
Total Program Cost:	2,721.8
Donor Financing:	
Pooled	371.2
Non-pooled	591.0
Borrower:	1,659.6
Total Bank Financing:	100.0
IBRD	
IDA	100.0
New	100.0
Recommitted	

Borrower: United Republic of Tanzania

Responsible Agencies: Ministry of Health and Social Welfare and Prime Minister's Office, Regional Administration and Local Government

Contact Persons: Ms. Regina L. Kikuli (MoHSW) and Mr. Pakshard Mkongwa (PMO-RALG
Telephone No.: +255-22-2138261, +255-26-2323164
Fax No.: +255-22-2668021, +255-26-2322116
Email: rlkikuli@yahoo.com

Estimated Disbursements (Bank FY/US$ m)

FY	2012	2013	2014	2015
Annual	23.0	25.0	26.0	26.0
Cumulative	23.0	48.0	74.0	100.0

Project Implementation Period: December 20, 2011 to June 30, 2015
Expected effectiveness date: March 1, 2011
Expected closing date: June 30, 2015

Does the project depart from the CAS in content or other significant respects?	○ Yes x No
If yes, please explain:	

Does the project require any exceptions from Bank policies?	○ Yes x No
Have these been approved/endorsed (as appropriate by Bank management?	○ Yes ○ No
Is approval for any policy exception sought from the Board?	○ Yes x No
If yes, please explain:	

Does the project meet the Regional criteria for readiness for implementation?	x Yes ○ No
If no, please explain:	

Project Development objective
Assist the Government of the United Republic of Tanzania in improving the equity of geographic access and use of basic health services across districts and enhancing the quality of health services being delivered.

Project description

Component 1 – Support to Local Government Service Delivery – will finance annual per capita grants to Local Government Authorities (LGAs) of approximately $0.30 per person per year to support service delivery at the district level, as well as funding medical supplies, medicines, vaccines and contraceptive commodities which will be procured centrally and used at the district level.

Component 2 – Capacity Building in Local Governments – provides funding through the Capacity Building Grant mechanism to improve the capacity of local governments to manage their health services, and would finance technical assistance, training and systems strengthening interventions, with a focus on improved public financial management (PFM), monitoring and evaluation (M&E), facility management, human resources management, procurement and governance and accountability mechanisms (including social accountability).

Component 3 – Central Programs to Support Local Service Delivery – provides funding for central level interventions including training, central level PFM and M&E initiatives, technical assistance for development of central level initiatives, management guidance through the Prime Minister's Office – Regional Administration and Local Government (PMO-RALG) and the Regional Health Management Teams (RHMTs), initiatives to support the performance management process at the central and regional levels, and strengthening of central level oversight structures.

Safeguard policies triggered?	
Environmental Assessment (OP/BP 4.01)	x Yes ○ No
Natural Habitats (OP/BP 4.04)	○ Yes x No
Forests (OP/BP 4.36)	○ Yes x No
Pest Management (OP 4.09)	○ Yes x No
Physical Cultural Resources (OP/BP 4.11)	○ Yes x No
Indigenous Peoples (OP/BP 4.10)	○ Yes x No
Involuntary Resettlement (OP/BP 4.12)	○ Yes x No
Safety of Dams (OP/BP 4.37)	○ Yes x No
Projects on International Waterways (OP/BP 7.50)	○ Yes x No
Projects in Disputed Areas (OP/BP 7.60)	○ Yes x No

Conditions and Legal Covenants:

Financing Agreement Reference	Description of Condition/Covenant	Date Due
Schedule 2, Section I, B.1	The Recipient shall update the Project Implementation Plan in form and substance satisfactory to the Association.	By no later than 3 months of effectiveness

Schedule 2, Section I, C.1	The Recipient shall prepare, and provide to IDA a work plan of activities to be included in the Project for the following fiscal year	Not later than June 1 in each calendar year
Schedule 2, Section I, C.3	The Recipient shall ensure that all Beneficiaries under Part A. and C.1 of the Project produce annual CCHPs and that a summary of the CCHPs is made available	Each year
Schedule 2, Section 1, C.4(a)	The Recipient shall ensure that the Association shall at all times have read-only access to the Recipient's central bank's real-time statement of the Special HBF Account	Within one month of Effectiveness
Schedule 2, Section I, C.4(b)	The Recipient shall furnish a statement of the Special HBF Account to the Association by electronic means	No later than the first working day of every month
Schedule 2, Section I, E.1	The Recipient shall make payments to the Beneficiaries for the carrying out of Subprojects in accordance with criteria and procedures acceptable to the Association set forth in the PIP	For Part A and C.1 of the Project, the execution of a Side Agreement by September 30 each year and production of a CCHP by every HBF Beneficiary by May 30 For Parts B.1(a), B.2(a) and B.3(a) of the Project, the delivery of a CBG Proposal by every CBG Beneficiary
Schedule 2, Section I, E.2	The Recipient shall make each Grant based on a CCHP, or CBG Proposal developed by the respective Beneficiary on terms and conditions approved by the Association	Each year

Schedule 2, Section I, G.1	The Recipient shall appoint external monitoring and evaluation experts for third-party appraisal of LGAs' compliance with CCHPs, CBG Proposals, and overall performance as regards Performance Indicators to be carried out under Part A.1 of the Project.	Within 6 months of the date at which the PIP is modified to reflect performance as a criterion for the determination of the amount of the HBF Grants to be disbursed to the respective LGAs under Part A.1 of the Project
Schedule 2, Section I, G.2	The Recipient shall: (i) cause said experts to carry out annual verifications of LGA's performance with respect to the Performance Indicators; (ii) obtain interim reports of said annual verifications; and (iii) transmit copies of such annual verification to the BFC	(i) by December 31 of each calendar year, (ii) by September 30 at the latest, and final reports by November 30 at the latest, of each calendar year (iii) within 5 days of receipt thereof.
Schedule 2, Section II, A.1	The Recipient shall monitor and evaluate the progress of the Project and prepare Project Reports	Not later than 45 days after the end of the period covered by such report
Schedule 2, Section II, A.2	Project completion and sustainability report	September 30, 2015
Schedule 2, Section IV, B.2	Except for initial advances authorized by the Association based upon expenditure forecasts for two consecutive calendar quarters consistent with annual work plans as documented in the CCHP, no withdrawals shall be made for subsequent advances under Category 1 for the HBF, unless and until a complete accounting of advances made to the HBF in the Predecessor Project is provided in a manner satisfactory to the Association.	Upon a complete accounting of advances made in the Predecessor Project.
Schedule 2, Section V, 6 (a)	Mid-term review	Within 30 months after effectiveness
Schedule 2, Section V, 6 (c)	Update MOU in a manner satisfactory to IDA	No later than 3 months after the effective date.

I. Strategic Context

A. Country Context

1. With a 2010 population of approximately 43 million, Tanzania is the 7th most populous country in Africa. The annual population growth rate is high (2.9%), and it is projected to remain high into the foreseeable future, dropping only to 2.7% by 2025. The National Bureau of Statistics population projection attributes this stable population growth rate to a combination of a significant decline in the Total Fertility Rate (TFR), and a reduction in the crude death rate, largely resulting from declining infant and under 5 mortality. As a result of these dynamics, Tanzania's total population is projected to increase to 65.3 million by 2025.

2. Tanzania sustained robust economic growth of around 7.0 percent from 2002 to 2008, driven by sound macroeconomic policies, market-oriented reforms, a favorable global environment and debt relief. However, one of the country's main challenges remains to translate economic growth into poverty reduction, with the country registering only a small decline in poverty incidence from 35.7 percent in 2000/01 to 33.5 percent in 2007. As a result of rapid population growth caused by consistently high fertility rates, the number of poor people actually increased by about 1.3 million over the period. The recent global economic slowdown will likely further impede poverty reduction efforts. The global financial crisis reduced Gross Domestic Product (GDP) growth from 7.4 percent in 2008 to 6.0 percent in 2009, but government stimulation measures resulted in 7.0 percent growth in 2010. The main sectors affected by the slowdown are the cash crop sectors (cotton and coffee), mineral sector, tourism sector, and manufacturing sector (mainly textile and leather industries), which underpin exports. Inflationary pressures grew in 2009, primarily due to food supply shortages in some parts of the country and in the neighboring countries and a rebound in world oil prices. However, following good weather and a bumper harvest in the 2009/10 crop season, food supply improved, leading to a downward trend in inflation from 12.2 percent in December 2009 to 5.6 percent in December 2010. Inflation resumed an upward trend during the first quarter of 2011, reaching 8.6 percent in April 2011 owing to the increase in the general prices of electricity, food and gas..

3. Despite the solid economic growth, the 2007 Household Budget Survey (HBS) poses a mixed picture of the country's progress in poverty reduction over the past eight years. Lower relative prices from imported goods and increased government spending led to tangible improvements in some areas, including ownership of consumer durables, housing quality, and some social indicators such as under-five mortality and enrollment in primary education. On the other hand, progress was limited in the areas of improvements in basic-needs income poverty, ownership of productive assets in rural areas, as well as some other social indicators, such as maternal mortality or access to safe water. Further, while both income-poverty incidence and the depth and intensity of poverty declined, the size of these decreases is small. The HBS indicates that per capita consumption increased by only 5 percent in real terms between 2000-01 and 2007, and in rural areas the reduction in poverty was not statistically significant. There was also a marked urban-rural gradient in poverty incidence, with the poverty head-count ratio in Dar es Salaam calculated at 16.4, compared to 24.1 in other urban centers and 37.6 in rural areas. The HBS showed a clear relationship between family size and poverty, with more than half of the households with 9 or more members being poor, compared to less than 20% of those with 4 or fewer members.

B. Sectoral and Institutional Context

4. Health services in Tanzania are provided through a decentralized policy environment, with Local Government Authorities (LGAs or "districts" – used interchangeably) running public dispensaries, health centers and district hospitals, while referral and tertiary hospitals are run through the Ministry of Health (see Annex 7 for further information on the structure of the health system). At the central government level, the Prime Minister's Office – Regional Administration and Local Government (PMO-RALG) oversees the LGA's and Regions. LGA's have very limited own revenue sources, so funding flows to local governments are mostly through the national budget. These flows include per capita allocations by Development Partners (DP's) through the Health Basket Fund (HBF).

5. The SWAp arrangement in general – and the HBF in particular – is a long-standing approach which has shown significant results. Table 1 provides an overview of progress in a number of key health indicators.

Table 1: Changes in Key Health Sector Indicators

Indicator	1999	2004/05	2009/10	% Change 2004-2009	% Change 1999-2009
Infant Mortality Rate	99	68	51	-25.0%	-48.5%
Under 5 Mortality Rate	147	112	81	-27.7%	-44.9%
Maternal Mortality Ratio	529	578	454	-21.5%	-14.2%
Births in Health Facilities	36 %	46%	51%	+10.9%	41.7%
Total fertility rate	5.6	5.7	5.4	-5.2%	-3.6%
Contraceptive prevalence rate (modern methods)	17%	20%	27%	+35%	+59%
TB Completion Rates	81%	82.6%	88.0%	+6.5%	+8.6%
Outpatient Visits per Capita	0.71	0.78	0.74	-5.1%	+4.2%
Clinical staff/10,000 pop.[1]	4.30	4.60	4.93	+7.1%	+14.7%

Source: Demographic and Health Survey, 2010; Annual Health Sector Performance Profile Report, 2010

6. It shows that there has been a reduction in the infant mortality rate by almost one half, from 99 deaths per 1,000 live births in 1999 to 51 in 2010, bringing Tanzania within reach of the child mortality Millennium Development Goal. There was also a 45 percent reduction in under-five mortality rate from 147 deaths per 1,000 live births in 1999 to 81 in 2010 due to an increased proportion of children under five sleeping under bed nets (from 36.3 percent in 2007/8 to 72.6 percent in 2009/10), increased vaccination coverage, vitamin A supplementation, and improved functioning Integrated Management of Childhood Illness (IMCI) at the facility and community levels.

[1] Includes physicians, assistant medical officers, nurses and nurse/midwives

7. A 2008 Lancet article on child survival gains in Tanzania attributed a large proportion of these improvements to investments in health systems and scaling up specific interventions through a decentralized approach. The funding through the HBF was mentioned as a contributing factor in this overall improvement. The Maternal Mortality Ratio also decreased by over 20 percent from 578 per 100,000 live births in 2004 to 454 in 2010, resulting in almost 2,000 fewer maternal deaths per year. The contraceptive prevalence rate (CPR) for modern methods also increased from 20 percent in 2004/05 to 27 percent in 2010 (26 percent to 34 percent for any method), after only modest changes the previous 5 years.

8. Despite these positive developments, a number of challenges still remain:

i. Very little progress has been made in reducing the Total Fertility Rate over the last 10 years, and contraceptive prevalence has only recently begun to improve;

ii. Significant variations still exist in health status, access to services and funding across regions and districts. For example, in 2009, the proportion of births in health facilities ranged from 28 percent in Tabora to 80 percent in Dar es Salaam, and the percent of pregnant women starting ante-natal care (ANC) before 16 weeks gestation ranged from a low of 26 percent in Arusha to 90 percent in Morogoro;

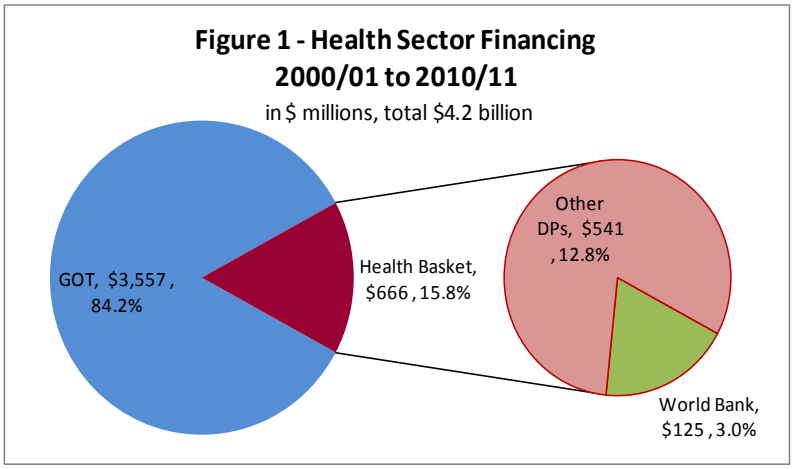
iii. There are also ongoing issues in the availability and distribution of health human resources. To address this issue, a comprehensive health human resources strategy has been developed, and a number of development partners, including the Global Fund, CIDA, and USAID are contributing to the implementation of this strategy. The goal is to have annual enrollment in training institutions of 10,000 by 2015;

iv. While some progress has been made, more needs to be done to improve the availability and distribution of medicines and medical supplies to health facilities.

v. Further work is needed to improve general management and public financial management at the local government level.

9. An external review of the SWAp process in Tanzania in 2007 concluded that the "*SWAp has contributed to improvements in health outcomes and to improvements in the quality of health services at community level. These improvements can, in turn, be plausibly linked to progress toward MDG and PRSP/MKUKUTA goals, especially relating to infant and child mortality*". Within the health sector, there is a clear Health Sector Strategic Plan (HSSP III), and good interaction between the Government of the United Republic of Tanzania (GoT) and other stakeholders on annual programming and the Medium Term Expenditure Framework (MTEF). Country systems are used exclusively for the HBF (including financial management, procurement, safeguards, monitoring), with the exception of international tenders, where the Bank (at the request of the HBF partners and the GoT), provides procurement oversight. The HBF is guided by a Memorandum of Understanding (MOU), which is signed by all parties, as well as annual Side Agreements, which specify the funding pledges for each HBF member, the allocation of the Basket Funds to various programs and activities and other conditions for the disbursement of these funds. A key decision which is reflected in the Side Agreement is the specific allocation of funds to districts, regions, PMO-RALG and the central MoHSW. Annex 7 (paragraphs 150-151) includes an assessment of how well the MOU arrangement is functioning.

10. The financiers and the amounts they contribute change on an ongoing basis, but annual financing has been around US$90 million over the last several years. It is expected to increase to US$116 million in FY12 (see table A7.3 in Annex 7). Current HBF partners include: Ireland, Germany, Canada, the Netherlands, Denmark, Norway, Switzerland, UNICEF, UNFPA, the UN and IDA. Figure 1 shows that the HBF contributed US$666 million to overall health sector financing over the last 11 years, representing 15.8 percent of the total, and the World Bank provided almost one fifth of the HBF financing. These resources represented the majority of the discretionary funding for the health sector over this period, as most other GoT funds were earmarked for salaries and various vertical programs.



11. The SWAp is an integral part of the health sector dialogue structure and it includes both Basket and non-Basket partners. Development Partners (DPs) participate in a Health Development Partner Group (DPG-Health), which is led by a "troika", comprised of a current chair, the outgoing chair and the incoming chair. The troika is the main conduit for conveying DP views to the government in between scheduled meetings. There are regular meetings attended by all key stakeholders, including representatives from relevant ministries, provider groups, civil society and development partners, which include a Joint Annual Health Sector Review, several Technical Committee (TC-SWAp) meetings per year and several HBF meetings to agree on the program of work and monitor progress. There is also a Technical Working Group structure which also includes all stakeholders and focuses on specific technical areas such as District and Regional Health Services, Health Financing, Health Human Resources and Maternal and Child Health. Further details regarding the dialogue structure are included in Annex 7.

12. Institutional arrangements in the health sector have been established as part of a comprehensive reform process through which political, administrative and financial decision making powers are being devolved to the LGAs. The GoT recognizes that, in order for the LGAs to provide services in an efficient, transparent, accountable and equitable manner, improvements are required in the intergovernmental legal, institutional and fiscal structures as well as the financial and human resource management capacity at all levels. Both the GoT and DP's are jointly promoting a number of underlying principles for their partnership arrangement, including: (i) implementing the Decentralization by Devolution (D-by-D) policy; (ii) promoting efficient and transparent budgeting and public financial management policies, systems and procedures at both central and local government levels; (iii) encouraging harmonization and alignment of recurrent and development financing of LGAs; (iv) developing predictable, stable, equitable and adequate formula-based allocations of intergovernmental transfers; and (v) promoting good governance, accountability by the Government to the citizenry, and integrity in public life, including the fight against corruption.

13. To support this process, a Local Government Development Grant (LGDG) mechanism has been established; including mechanisms for DPs to transfer capital and capacity building funds to local governments (Council Development Grants (CDG) and Capacity Building Grants (CBG) respectively). In addition to the Health Basket Fund, the World Bank also contributes to three other basket funds which support LGAs in local government, agriculture and water. The projects in these sectors use one or more of the CDG and CBG, as well as non-pooled mechanisms. Annex 9 contains a more detailed comparison of these projects. Together they represent over US$700 million in support to LGAs and the relevant central ministries. There are also other basket funds which the Bank does not support, such as the health window of the LGDG and the HIV/AIDS Basket), and several other baskets which are not targeted to LGA's.

14. The principles mentioned above recognize the need to rationalize existing funding arrangements, and consolidate these mechanisms into a more limited set of funding streams within an overall LGDG system run by Government. While mechanisms exist for DPs to transfer capital and capacity building funds to local governments, there is no parallel vehicle to fund ongoing operating costs. This deficiency needs to be addressed to fully support LGAs in all aspects of their emerging responsibilities.

15. Since the HBF was the first basket fund in Tanzania and already contributes substantially to the operating costs of health services at the LGA level, it has the potential to be used as a vehicle for developing a common mechanism for funding operating costs. Other basket funds have had difficulties in terms of the implementation arrangements and Public Financial Management (PFM) issues, and while the HBF is generally considered to be the best performing, there are still issues of local capacity, reporting and PFM which will require ongoing attention and improvement. The challenge, therefore, is to maintain the benefits of the current health basket arrangement while addressing both these issues and the need to mainstream the funding flows within the overall structure for intergovernmental fiscal transfers.

C. Higher Level Objectives to which the Project Contributes

16. A new Country Assistance Strategy (CAS) was presented to the Board in June, 2011. The CAS is designed to support the government in its pursuit of the MKUKUTA goals, and focuses on the following four objectives:

(i) Promote Inclusive and Sustainable Growth
(ii) Build Infrastructure and develop Services
(iii) Strengthen Human Capital and Social Safety Nets
(iv) Promote Accountability and Governance

17. This project will contribute to the third objective, which includes outcomes related to improvements in the access and quality of health care delivery. Because of the timing of the CAS, there is a direct correlation between the CAS goals and the related project objectives. The project would contribute to the World Bank's Africa Strategy by addressing Pillar 2 – Vulnerability and Resilience – by helping to improve access and quality of health services, and to Pillar 3 – Governance and Public-Sector Capacity – by strengthening accountability and building capacity of the health system at both the central and district levels.

II. Project Development Objectives

A. PDO

18. The PDO for this project is to *assist the Government of the United Republic of Tanzania in improving the equity of geographic access and use of basic health services across districts and enhancing the quality of health services being delivered.* This would be achieved by introducing innovative financing mechanisms for health service delivery which encourage both effective and efficient management of health services at the local level and a focus on quality improvement, and would be accomplished within the framework of the Health Sector Strategic Plan III.

1. Project Beneficiaries

19. The project would benefit all Tanzanians who use publicly financed health services since the grants to local authorities, as well as the medical supplies and medicines provided through the Health Basket Fund, would cover every district. The Bank's contribution to the HBF is expected to be about 20 percent of the total basket Funds, so this could reach an estimated 8-9 million people per year.

2. PDO Level Results Indicators

20. The following indicators will be used to measure improvements in accessibility, use and performance:

i. Births taking place in a health facility (percent, national and broken down by LGA – *access to and use of health services*)
ii. Average outpatient attendances per clinical health worker by LGA (number, national and broken down by LGA – *efficiency in delivery of health services*)
iii. Average outpatient attendances per capita by LGA (number, national and broken down by LGA – *access to and use of health services*)
iv. Health facilities with any stock-outs of tracer medicines and vaccines (percent, national and broken down by LGA – *quality of health services delivered*);
v. Ratio of the 10 best performing LGA's to the 10 worst performing LGA's in indicators (i) through (iii) (*variation in access, use and quality of health services*)

B. Project Description

21. The project would seek to improve the performance of districts and front-line health facilities by changing the way in which Health Basket Funds are allocated to districts. This would include moving from the current unconditional grant approach – which considers population, poverty levels, long road distances and burden of disease (see Annex 7 for more details on the existing allocation formula) – to one which also considers both performance and equity aspects at the LGA level.

22. The performance-based aspects would focus on the extent to which districts are using their existing funding effectively, regardless of their current level of funding, and the degree to which they meet specific performance and quality objectives. By focusing on factors which are within the control of the LGA, improved performance should be encouraged. LGA's which are not using their existing funding effectively have little reason to argue for additional financing.

23. The equity-oriented aspects would focus on the extent to which financial and human resources are equitably distributed between districts based on objective criteria of need across districts. In this regard, it would attempt to reduce geographic variations by directing more funds to those districts which are currently under-resourced, and less to those who already have a proportionately larger share of the available resources. Clearly there is a tension between performance and equity considerations, as well as factors outside the control of the LGA – including constraints imposed by the central authorities – so care will be taken to ensure that the performance indicators and targets take these factors into consideration. LGA's which score poorly on the selected performance indicators will be given priority access to capacity building funds which should allow them to perform better in the future.

24. Once the Health Basket Fund has been changed to incorporate performance and equity elements, the project would then look at transforming it into a more generalized Service Delivery Grant (SDG) mechanism which could be used in multiple sectors and would complement the CDG and CBG mechanisms already in place. This would allow the integration of all three grants into the overall local government support (LGDG) framework. SDGs would be used to finance operating costs, similar to those currently financed through the HBF. Allowable expenditures for the health basket fund will include: medicines and medical supplies which cannot be supplied by the Medical Stores Department (MSD), fuel, local training, allowances for supervision and distribution activities (e.g., distribution of vaccines or medical supplies – no other types of allowances are permitted), maintenance of vehicles, and planned preventive maintenance of technical and medical equipment and health facilities.

25. It is expected that the SDG would maintain separate allocations for each sector, with performance and equity allocation criteria specific to that sector. Similarly, individual DPs would continue to make sector-specific allocations, which would be pooled and distributed to the LGAs in each sector according to the sector-specific allocation formulas. The DPs which are active in each sector and the relevant and central ministries would continue to play a role in determining these allocations. For example, in the health sector, the use of the amounts allocated at the LGA level would continue to be covered in the Comprehensive Council Health Plan (CCHP), and budgeted accordingly. Thus in the health sector, there should not be a significant change in the dialogue structures and processes. The impact on other sectors will depend on their current structures and approaches. The main change would be that the process used in determining the LGA allocation for each sector would be the same across all sectors. Thus, the SDG would operate in a similar way to the current CDG and CBG, with sector-specific dialogue being maintained. In order to facilitate these transitions, the project would specifically focus on strengthening public financial management and monitoring and evaluation at the local level.

26. The project would run for four years, covering both the evolution of the HBF into a more performance-based and equity-oriented mechanism, as well as the evolution from a health-only basket to a multi-sectoral Service Delivery Grant mechanism. It would include US$20 million per year to the health basket for district services, plus $20 million over the life of the project for institutional strengthening, including $5 million through the HBF. It is expected that the SDG mechanism would be operational in the final year of the project, although this would depend on discussions with other stakeholders and the pace of institutional strengthening initiatives.

A. Project components

27. The project would have three components with the following structure (all costs IDA):

28. *Component 1 – Support to Local Government Service Delivery* (indicative cost US$80 million) – will finance annual per capita grants to LGA's averaging approximately US$0.30 per person per year to support service delivery at the district level, including support for private not-for-profit and faith-based providers (FBO's) where they are providing health services on behalf of the Government. The specific use of these funds will be determined through the CCHP process, according to the relevant guidelines (see paragraph 24 on the types of expenditures which would be financed and Annex 7 for more details on the process), and the MoHSW approval of each council's CCHP. This Component will also fund medical supplies, medicines, vaccines and contraceptive commodities which will be procured centrally and used at the district level. Two options would be considered for determining the allocation at the district level:

a) use a set proportion of the total funds – possibly 80% – to determine a basic grant which would be made to all districts based on the current allocation formula, and then allocate the balance of the funds using the performance and equity measures;
b) allocate the total amount using the current allocation formula, and then adjust this amount upward or downward based on performance and equity considerations.

29. The specific approach would be determined during the first year of project implementation, and reflected in the CCHP guidelines. Eligible expenditures would not change. The process for allocating the HBF would evolve to include both performance and equity elements, and the annual amount of the grant, the performance and equity measures to be used, and the specific allocation approach would be set by the Basket Financing Committee.

30. *Component 2 – Capacity Building in Local Governments* (indicative cost US$11 million) – provides funding through the CBG mechanism to support councils whose Capacity Building Plan includes capacity measures for improving the management of health services. The grant would finance technical assistance, training and systems strengthening interventions, to help improve overall performance at the LGA and health facility level. Depending on the reasons for poor performance, LGAs which scored lower in the selected performance measures would be given priority access to this grant. The initial focus will be on improved public financial management (PFM), monitoring and evaluation (M&E), facility management, human resources management, procurement and governance and accountability mechanisms (including social accountability), but other areas may be added if circumstances warrant. The MoHSW and PMO-RALG would be fully engaged in the dialogue and developing the criteria and mechanisms for the development, evaluation and distribution of funds for health related CBGs.

31. This component would also finance cost-effective centrally managed interventions which would provide additional support to LGAs and health facilities. For example, in the area of PFM this component would finance the creation of financial management support teams (including consultants, equipment, vehicles and operational costs) at the zonal level, as well as a central level team to focus on improving budgeting, planning and financial reporting. Similarly, funds to support M&E would be aligned with the existing M&E Strengthening Initiative, which is designed to roll out an improved Health Management Information System (HMIS) throughout Tanzania, and is already supported by a number of development partners, including the Global Fund, the Netherlands, and Norway. The use and distribution of funds between CBG and centrally managed mechanisms would be reviewed and revised during project implementation based on experience with each approach.

32. *Component 3 – Central Programs to Support Local Service Delivery* (indicative cost US$9 million) – as part of the overall health system, the MoHSW, PMO-RALG and the regions have important roles to play in effective local service delivery. This component therefore provides funding through both the Health Basket (US$ 4 million) and non-pooled funding (US$ 5 million) for central level interventions including: (a) providing technical assistance, training and other support to improve the development and implementation of Comprehensive Council Health Plans; (b) providing technical assistance to develop independent data verification approaches and promote social accountability mechanisms for an enhanced performance management process; (c) carry out an impact evaluation of the introduction of performance and equity indicators to the Allocation Formula; (d) along with other development partners, support an external evaluation of the HSSP III; (e) carry out an independent audit to assess the performance of the LGAs; (f) support priority interventions in the National Action Plan (NAP) for Health Care Waste Management (HCWM) in the areas of NAP implementation, the legal and regulatory framework for HCWM, improving HCWM practices, management and monitoring, providing HCWM equipment and training; and, (g) support other interventions developed during the life of the project which will enhance the overall implementation of the Health Sector Strategic Plan III and the Project.

33. To improve the impact of the HBF, the following sequence of steps would be expected in moving from the current HBF approach towards the SDG mechanism:

a. Develop and agree upon a mechanism for assessing performance and equity, together with MoHSW, PMO-RALG and HBF DP's (FY12);
b. Introduce initial performance and/or equity factors into the HBF allocation formula (FY13);
c. Review the operation and impact of the initial set of factors and agree on a final set of factors and performance assessment mechanism (FY13);
d. Incorporate the final set of performance and equity factors into the formula (FY14);
e. Discuss the expansion of the revised HBF to other sectors with the relevant ministries and DP's (FY12-14);
f. Agree on sector specific performance and equity factors which would be incorporated into the formula for each additional sector (FY13-14);
g. Incorporate additional funding for the new sectors and the relevant performance and equity factors into the new SDG (FY15);
h. Evaluate the process for the allocation using the new formulas and sectors (FY15).

B. Project Financing

1. Lending Instrument

34. The project would be a Sector Investment and Maintenance (SIM) Credit. A Sector Investment and Maintenance instrument (SIM) is chosen because the project will focus on the sector's entire expenditure program (as described by the medium term expenditure framework-MTEF) and will help to strengthen the health systems of the country. A SIM brings sector expenditures, policies, and performance in line with a country's development priorities and helps develop the country's institutional capacity. A Development Policy Loan (DPL) would not respond to the needs to invest in building the sector's capacity. A Specific Investment Loan (SIL) would not recognize the programmatic nature of this Project. Similarly, an Adaptable Program Loan (APL) was discussed and rejected because the GoT's Program is not a multi-phased program and the Project support needs to be aligned with the Program's time frame.

2. Project Cost and Financing

35. The total IDA financing would be US$100 million over a four-year period, as shown in the table below. Pooled financing would be US$85 million, including US$80 million in Component 1 and US$5 million in Component 3.

Project Components	**Total Program cost (US$ million)**					
	GoT own funds	**DP non-pooled**	**DP Pooled**	**IDA Financing**	**Total Cost**	**% IDA Financing**
1. Support to Local Government Service Delivery	780.0	166.9	296.9	80.0	1,323.8	6.0
of which – to LGAs	780.0	166.9	189.5	56.9	1,193.3	
2. Capacity Building in Local Governments		40.0		11.0	51.0	21.6
3. Central Programs to Support Local Service Delivery[2]	879.6	384.1	74.3	9.0	1,346.9	0.7
of which – IDA pooled				5.0		
Total Financing	1,659.6	591.0	371.2	100.0	2,721.8	3.7

36. Pooled funds are expected to total US$456 million over the next four years, with US$85 million (19%) of that coming from IDA, and $371 million from other DPs. The proportion of IDA funding should allow the Bank to leverage its investment to maximize the policy impact. The Bank has always played an important role in the development and management of the health basket fund, and it is expected that this level of financing, together with the clearly stated objectives of this project, should allow the Bank to continue to provide leadership to the further development of the HBF. The project will also provide specific additional funding to build capacity at the local level, estimated at about 21.6% of the total capacity building funds provided to LGA's during the project implementation period. Again this should be sufficient to have a substantial impact on the ground. Finally, although the allocation for central programs is not large in percentage terms, the fact that this amount will be specifically targeted to increasing central support for local service delivery should ensure that the IDA financing will help to stimulate improvements in this area.

[2] GoT own resources and DP amounts include central expenditures not specifically related to supporting LGAs.

C. Lessons Learned and Reflected in the Project Design

37. The Lancet article, as well as the independent external evaluation emphasized **the value of Sector-Wide Approach as part of a systematic approach to increasing investments in health systems and scaling up specific interventions through a decentralized approach**. This leads to a fundamental design feature which is to "first, do no harm" to the underlying HBF mechanism while working to improve its effectiveness and scope.

38. The experience with the existing basket funds also clearly shows **the importance of improving public financial management and monitoring and evaluation systems**, both in terms of ensuring that existing funds operate effectively and providing the necessary basis for more performance based and equity focused allocation approaches. This is guided by planning and budgeting through the Comprehensive Council Health plans (CCHP). Accordingly, the project puts significant emphasis on the development of these systems, with appropriate emphasis on the district and health facility level.

39. While there is consensus that changes are needed, there is also agreement that **an evolutionary approach is most appropriate**. This reflects the need to ensure that ongoing funding is maintained while necessary changes are initiated, as well as the reality that the new mechanism will require improved PFM and M&E systems. Thus, an evolutionary approach will allow changes to be made over time and as the underlying conditions and necessary systems are put into place or improved. This is reflected in the project design, which uses the existing Health Basket Fund as the starting point and seeks to transform this fund into a generalized financing mechanism as conditions permit.

40. The experience with the current Health Basket Fund indicates the **growing importance of closer interaction and dialogue with the regional and local levels of government** as part of the overall sector dialogue. While this is already being discussed as part of changes to the annual health sector review process, and is otherwise being pursued within the sector, the project will further institutionalize these important linkages and provide support to strengthening the governance and accountability structures at the district and facility levels. Very close supportive supervision and coaching will also be needed at the regional and district level to effect these changes.

41. The experiences of other countries in results based financing (RBF) were examined during the concept stage of the project, and it was concluded that **it was most appropriate to modify the existing financing structures in Tanzania**, rather than setting up an RBF scheme using completely new implementation arrangements.

III. Implementation

A. Institutional and Implementation Arrangements

42. The project would include both pooled and non-pooled expenditures and be implemented using existing country mechanisms. The project managers will be senior managers within the Ministries of Health and Social Welfare and PMO-RALG, and the project will be mainstreamed within GoT operations and managed within the existing set-up in the MoHSW, PMO-RALG and

the LGAs. The Permanent Secretaries of the two ministries will take full fiduciary responsibility as the accounting officers while the day-to-day financial management transactions will be processed by the Chief Accountants of the MoHSW and PMO-RALG. The implementing agencies are experienced in both pooled and non-pooled financing arrangements and should be able to adapt relatively quickly to any changes in the procedures, since they will largely utilize existing mechanisms and structures. It is not expected that any new structures will be required to support this project, although specific procedures will be needed within existing structures to deal with service delivery (operating) versus capital issues, and explicitly evaluate Capacity Building Plans to identify health related priorities.

43. LGA's will continue to use the Comprehensive Council Health Plans to plan and budget for their health allocations, and would utilize existing planning processes in other sectors should the SDG be expanded. The review and evaluation of the LGAs which would be required for determining performance-based and equity oriented allocations is also not much different from what is already being done during the CCHP review by the MoHSW and PMO-RALG. It is expected that incorporating these procedures into the overall LGDG mechanism should help simplify the process over the longer term.

44. Since the indicators used are taken from sector development strategy and will already be reported on a regular basis, this should pose no additional burden on LGAs. The monitoring and evaluation strengthening initiative which has already started should also help strengthen the regular reporting of both project and other indicators. The increasing emphasis on including the regional and LGA levels in the policy dialogue – which is already being pursued – will further support their involvement in project implementation.

B. Results Monitoring and Evaluation

45. This project is designed to support the implementation of the Health Sector Strategic Plan (III), thus the indicators selected are largely taken from agreed HSSP III indicators. These indicators are produced as part of the overall health sector Monitoring and Evaluation (M&E) system and are regularly reported in the Annual Health Sector Performance Profile Report (AHSPPR), which is discussed during the Joint Annual Health Sector Review. Other specific indicators which will look at performance and equity issues will also be extracted from existing systems (e.g., budget or human resources systems). A Technical Working Group (TWG) on M&E is in place as part of the current dialogue structure, and it will guide the development of health sector M&E systems.

46. In this regards, a comprehensive M&E Strengthening Initiative (MESI) is currently underway to improve the overall level of monitoring and evaluation, both in terms of timeliness and accuracy. It includes efforts to: (i) **implement M&E Policy guidelines** to facilitate the harmonization and better use of information, and its rationalization; (ii) **strengthen disease and demographic surveillance**, (iii) **strengthen the routine HMIS** to function effectively at all levels and provide timely, quality data which is used for planning, management, monitoring and evaluation of the health sector; (iv) **improve data management** to ensure that appropriate information is accessible, using appropriate Information and Communication Technology (ICT), including the internet and a data warehouse approach that integrates different subsystems and

databases; and, (v) **improve the rationalization, coordination, and harmonization of surveys and operational research** and ensure they complement the routine HMIS and fit in the M&E plan of the health sector.

47. The HMIS strengthening part of MESI features two integrated approaches; 1) a rapid regional deployment (”top-down”) of the national HMIS and 2) medium term district roll-out (“bottom-up”). The top-down approach ensures national coverage and consolidation of the revised HMIS, while the bottom-up approach ensures continuous system strengthening, improved use of information for monitoring, planning and management at all levels, further revisions of data sets and more in-depth capacity building. These two approaches also reinforce the need to ensure that the paper based HMIS system co-exists and is synchronized with the electronic system. The deployment of the DHIS software to all districts will take time and will require capacity such as data entry at the regional level to meet short term data requirements. A significant feature of the MESI design is emphasis on Regional and Council Health Management Team ownership, leadership and sustainability of all HMIS systems and strengthening activities in their localities. After the initial rolling out the HMIS software to all 21 regions, additional support from MESI will be based on the demonstrated commitment and readiness by regions and districts to implement additional HMIS activities and establish DHIS software in districts.

48. Prior to the end of HSSP III (2015), it is expected that there will be another external evaluation similar to the one which was completed in 2007. Funding will be set aside from Component C both to assist in financing this evaluation, and to specifically evaluate the impact of implementing the performance and equity features within the LGA grant.

C. Sustainability

49. The current Sector Wide Approach in health has been operational for over 10 years, and there is expected to be an ongoing need for external financing in this sector. There is a strong level of commitment by both development partners and the government to continuing with the SWAp approach and the HBF in particular, thus there is every expectation that this approach is sustainable into the future. However, while the structures are expected to remain, there will likely be changes in the composition of the DP group, and the level of resources that they are prepared to commit to the HBF. Recent examples of this include the decision by the Netherlands to focus on fewer countries and cease its support for Tanzania, including its funding for the HBF. On the other hand, Canada has recently announced a significant increase in funding for the HBF because of its expected ability to influence maternal, neonatal and child outcomes at the local level. Further, both the United Kingdom and Australia are now becoming more active in the health sector, representing more potential participants in the HBF.

50. The intention of this project to support the evolution of the HBF into a performance based, equity focused, multi-sectoral service delivery grant which is integrated into the overall local government support framework, should help to further enhance sustainability since SDG will be part of the overall intergovernmental fiscal transfer (LGDG) system. It is expected that once this SDG is in place and functioning well, an increasing number of Development Partners may see it as an attractive option for ensuring that development funding for service delivery in both health and other sectors reaches its intended destination.

IV. Key Risks and Mitigation Measures

51. Two sets of risks have been identified. The first set center around the implementation of a new funding modality to support the ongoing operating costs of service delivery at the district level. Since the approach desired at the end of the project is new, care will need to be taken to ensure that it is effectively integrated with the existing approaches such as the Comprehensive Council Health Plans (CCHP), and that both Government and DP support for this modality is garnered and maintained. Adequate integration into the overall LGDG process will also be needed, recognizing the current limitations of that approach. The second set of risks reflect the realities of dealing with the LGA level in Tanzania, including issues of capacity, governance, and ensuring the actual achievement and monitoring of results.

52. Risk mitigation in the first set of risks focused primarily on the project preparation process, where active engagement of all stakeholders was pursued to ensure their support for moving forward. During project implementation, this risk will be mitigated by ensuring that existing, operational structures continue to operate successfully while new mechanisms are developed, and until they are ready to be implemented. The step-wise approach which has been developed for moving to a performance-based and equity oriented financing mechanism and from there onward to a multi-sectoral approach rooted in the LGDG will ensure that each step of the process is tested before moving ahead to the next step. This will be supported by ongoing assessment of the results at each stage of the process. The focus on improving PFM and M&E systems should ensure that the decisions to proceed with each step in the development of the new funding modality are supported by systems and procedures which will allow both a smooth transition and the appropriate functioning of the financing mechanism. Consultations that have been held to date indicate support for the concept, and this momentum will be pursued further with a variety of stakeholders throughout project implementation.

53. One of the concerns regarding the current Council Development Grant (CDG) allocation process within the LGDG is the fact that practically all districts achieve a rating which allows them to get the full CDG allocation. In contrast, the SDG will create a “zero-sum” environment where the available funding is spread across the LGAs based on how well each LGA performs. Other aspects of the LGDG system will be carefully reviewed during project implementation to ensure that the negative aspects are fully understood and mitigation measures put in place prior to moving towards full integration with the LGDG. This process will also draw on the independent evaluation of the LGDG system which is currently underway and financed through the Bank’s Local Government Support Project.

54. Mitigation measures in the second area will focus on funding specific improvements in public financial management ($5 million sub-component) and monitoring and evaluation ($3 million sub-component). The interventions are designed to complement the ongoing work and initiatives of other development partners in these areas, and the existing dialogue structure will ensure ongoing coordination with both DP’s and the relevant ministries. The interventions in Component 3 should ensure that central level structures are put in place to complement the PFM and M&E strengthening initiatives at the local level. The overall risk rating for this project is Substantial (see the full ORAF – Annex 4 – for more details) as shown below:

Stakeholder Risk	Moderate
Implementing Agency Risk	
- Capacity	Substantial
- Governance	Substantial
Project Risk	
- Design	Substantial
- Social and Environmental	Moderate
- Program and Donor	Low
- Delivery Monitoring and Sustainability	Substantial
Overall Implementation Risk	**Substantial**

V. Appraisal Summary

A. Economic and Financial Analysis

55. Total public health sector spending in nominal terms in the 2010/11 budget estimates are almost 4 times the level in 2004/05. The largest increase has been in foreign non-basket funding and a substantial part of this is due to the Global Fund grants now being shown "on-budget". Spending per capita has increased by a factor of 2.5, from US$7.51 to US$18.56 (estimates); although actual expenditure is often lower than the estimated amount. Excluding debt service and related items, the percent of the total government budget spent on health increased from 11.3 percent in 2004/05 to 14.1 percent in 2005/06 and then declined steadily to 12.1 percent in 2008/09. Some improvement occurred in 2009/10. These increases are largely the result of growth in Global Fund (GF) Grants, which more than doubled from TZS 152.7 billion (equivalent to 31.9 percent of the total MoHSW budget) in 2009/10 to TZS 333.7 billion in 2010/11 (or 49.3 percent of the budget). Excluding the GF, the development budget increased by just 6.3 percent from TZS 107.9 to 114.7 billion, while the total budget increased by just 5.0 percent from TZS 326.3 to 342.5 billion. The recurrent budget increased by just 4.3 percent, which is barely above population growth.

56. Government financing is decreasing as a proportion of total funding – from 69.1 percent in 2005/06 to 53.9 percent in 2010/11 (estimates). These figures emphasize that the amount of GoT's own revenue available for the health sector is constrained. In the future, the combination of shrinking pledges to global health initiatives and the rapid utilization of the funds from existing Global Fund grants could result in smaller budget increases or possibly even decrease in the health sector budget. However, the scope for increased financing is limited by the current fiscal situation, which expects an overall budget deficit of 6.1 percent of GDP (12.1 percent before external financing) in 2009/10, up from 4.5 percent (9.4 percent) the previous year. This suggests that the fiscal space in terms of budget resources is very limited.

57. The funding provided through this project would continue to support the health basket funds, which has been shown to have a positive impact on health outcomes. As noted in Table 1, Tanzania is on track to achieve the MDG in Under-5 mortality, and it is expected that the HBF will continue to play a role in the achievement of these targets. For under-5 mortality, this means a decrease from 81 per 1,000 live births today to 64 per 1,000 in 2015.

58. The achievement of these MDG would result in about 8,600 fewer infant and child deaths in 2011, increasing to 43,200 fewer deaths per year by 2015, the year in which the MDG targets would be reached. Using the average value added per year of US$864.46 calculated from the Integrated Labor Force Survey of 2006 (updated to current GNI per capita), this translates into a discounted lifetime contribution to the economy of US$21 million in 2011, increasing to US$105 million in 2015 and each year thereafter. These contributions are discounted over the working life of those whose lives have been saved using the Internal Rate of Return (IRR). The IRR was set to equate the value of benefits to the costs incurred. As shown in the table on project costs and financing, the IDA funding is expected to account for 3.67 percent of the costs of the publicly financed health sector between 2011/12 and 2014/15, thus that proportion of the benefits have been assigned to this investment.

59. The economic analysis shows that the IRR for this project would be 8.70 percent, based solely on the achievement of MDG 4. Clearly the impact of the project would be substantially greater than only MDG 4, but on the other hand there will be factors outside of the health system which will also have an impact on MDG 4. This rate of return can therefore be seen as a fairly conservative estimate of the impact of the project using data that is readily available

B. Technical

60. The technical issues regarding the necessary improvements in PFM and M&E are well known, and processes are already in place to address these issues. In this regard, the project will help facilitate these improvements by providing additional funding for these processes. In terms of the change in orientation of the HBF from an unconditional grant to a performance-based and equity oriented conditional grant, the Bank has considerable experience in implementing various types of performance or results-based financing approaches, including in Africa (e.g., Rwanda, Burundi), Latin America (e.g., Mexico, Brazil) and South Asia (e.g., India, Afghanistan) and these experiences will be reviewed and adapted during implementation to fit the Tanzanian context. This will be further supported by specific AAA which is currently included in the CAS. This AAA will also help to address the transformation of the HBF to a multi-sectoral funding mechanism. Any technical risks that might arise in this approach will be mitigated by making incremental changes over time and preserving the essential nature of the HBF until there is wide-spread agreement to expand beyond the health sector.

C. Financial Management

61. As part of project preparation, a full financial management assessment was carried out at the central level (MoHSW and PMO-RALG) and at some selected LGAs in accordance with the Financial Management Practices Manual issued by the Financial Management Sector Board in

March 2010. The objective of the assessment was to determine whether MoHSW and PMO-RALG and LGAs have adequate financial management arrangements to ensure that project funds will be used efficiently and economically for their intended purposes. The review examined the government financial management system (budgeting, staffing, financial accounting and reporting, funds flow and disbursements, internal and external audit arrangements), and included the following LGAs: Korogwe Town Council, Arusha Municipal Council, Monduli District Council, Misungwi District Council, Shinyanga Municipal Council, Igunga District Council, Iramba District Council, Dodoma Municipal Council, and Chamwino District Council.

62. At the central level it was noted that the two ministries have good experience in implementing IDA projects and have adequate and qualified accountants to manage IDA funds. Unaudited Interim Financial Reports (IFRs) are submitted on time, reviewed and found to be satisfactory. The accounting systems in the two ministries comply with International Public Sector Accounting Standards requirements. At the LGA level it was noted that overall, the FM system is in place with adequate staff, majority of LGAs visited are now using Epicor and all accountants have attended training ready to use new Epicor upgrade. The Internal auditor prepares quarterly reports, but the quality of the reports needs to be improved. Funds are being transferred on time to majority of LGAs visited. Annual Work Plans are prepared through MTEF process and budget data input is done in the parallel system called PlanRep. The review also took into consideration the National Audit Office (NAO) performance audit report of 2010 which covered performance of the Health Sector previous audit reports of the Health Sector Program (both central and local governments) funded jointly by the Bank and other Development Partners and recent audit reports of MOHSW, PMO-RALG, and overall audit performance of LGAs. Review of the above indicate specific weaknesses in the following areas: misuse of public resources, non compliance with public finance, poor flow of funds, incomplete reporting, unsatisfactory procurement practices at all levels, irregular retention of end of year balances, and weak internal audit functions and controls which impact health service delivery.

63. **Country PFM issues.** A Public Expenditure and Financial Accountability assessment was done for Tanzania in June 2006 for LGAs and November 2010 at the central level. These reviews highlighted weaknesses and strengths in the public financial management system. The government continues to produce timely consolidated financial statements for Central government on the basis of International Public Sector Accounting Standards (IPSAS)-accrual basis, Internal Audit function is been strengthened at both Central and LGAs and made independent, a new Public Finance Act was approved in July 2010 , and there have been major improvements in the functioning of the procurement regulator and the NAO in terms of moving to risk based auditing and value for money audits, including timely submission of audit reports for both central and local government to the parliament. The Integrated Financial Management Information System (IFMIS) is been strengthen at all LGAs with new Epicor version 9.05 being rolled out to all 132 LGAs. The system captures all payments made through the exchequer system and facilitates a rapid sector/project and development partner finances and expenditure tracking process. More increase oversight role is being provided by the two public finance committees (central and local government) in strengthening accountability of public resources at all levels. Challenges still remain in improving budget classification and reporting, IFMIS, cash management, fund flow and internal controls.

64. **PFM strengthening at Central and LGAs under this project.** Part of funds for component 2 (capacity building in Local government) and Component 3 –(Central programs to support Local service Delivery) of the project will focus on improving PFM issues including technical assistance. These two components would finance the establishment of financial management support teams at the regional/zonal level, as well as a central level team to focus on improving budgeting, planning and financial reporting and internal controls. It will also provide support to strengthening the governance and accountability structures at the district and health facility levels. In addition to the above mitigation measures, the Government has a Public Financial Management Reform Program under the IDA-financed Accountability, Transparency & Integrity Project, which is helping in addressing the PFM issues identified in the PEFA**.**

65. **Governance.** In terms of accountability, the systems and structures for financial management, auditing (internal and external) risk management and corruption prevention are been strengthened. A risk based approach has been adopted and institutionalized in both auditing (external and internal). The Internal Audit has been strengthened through the establishment of Internal Auditor General Office and appointment of Internal Auditor General overseeing internal audit functions of the government at all levels. Establishment of Audit Committee at central and LGAs, and increase in the number of skilled auditors (both internal and external auditors). Lastly, more increase of budget scrutiny by parliament and oversight role provided by the two public finance committees (central and local government).

66. The conclusion of the assessment at all levels is that financial management arrangements have a **Substantial** risk rating. Satisfactory implementation of Component 2 and 3 of the project which focus among other issues on strengthening PFM issues at all levels (central at LGAs), continued strong oversight role played by the joint program steering and audit committees, and close FM supervision of the project at all level will be essential in mitigating this risk and improving the FM arrangements of the project.

67. **Compliance with FM legal covenant of the recently closed project**: Unaudited Interim Financial Reports (IFRs) were submitted on time, reviewed and found to be satisfactory. The external auditors issued a clean audit report for the year ended June, 2010 for the activities funded out of the basket funds. Audits of the basket fund released to the ministries and LGAs are up to date, have been reviewed by the Audit Sub-committee, and appropriate plans of action for dealing with the audit recommendations have been developed and discussed.

68. **Disbursement arrangements.** The disbursement arrangements proposed for this operation would rely on the continued use of the Basket Fund, which would be considered the pooled Designated Account for disbursing advances into the project. Considering the complexity caused by multiple donors pooling funds and the modest share of IDA financing as % of the total program, for expenditures to be financed by the Basket Fund along with other donors, only the Advance method of disbursement would be authorized. For the expenditures financed only by IDA in a non-pooled manner, amounting to an aggregate of US$15 million equivalent over the project period, Advance, Direct Payment and Reimbursement methods would be authorized. Two Designated Accounts (Non-pooled) will be opened, one for the CBG, managed by PMO-RALG, and one for other non-pooled expenditures, managed by the MoHSW. Financial reporting, both quarterly and annual, would report separately the receipts and expenditures attributed to each financing source participating in this operation, as a measure of harmonized

reporting. Such quarterly reports would be used for documenting advances and seeking replenishments. To help maintain accountability, these reports would include opening and closing balances at both the pooled Basket Fund Account as well as cash / bank balances in project bank accounts and LGAs. Advances attributed to the Association and remaining unspent or undocumented in the Basket Fund Bank Account at the closing date of the project should be refunded to the Association before the Disbursement Deadline date.

69. It is proposed that the Basket Fund for the current Health Sector Development Project would continue to be used for this operation. Accordingly, a satisfactory and complete accounting for the IDA advances given in the Basket Fund for the predecessor operation would be a condition of disbursement. A flexible ceiling for Advances would be authorized, based on expenditure forecasts for rolling 2 quarters consistent with annual work plans as documented in the CCHP. The proportion of sharing among donor partners will be determined on an annual basis and would be reflected in a periodical Side Agreement between donors and the Govt. of Tanzania. Further disbursement details will be given in the Disbursement Letter to be issued.

D. Procurement

70. Procurement will be carried out in accordance with the World Bank Guidelines: Procurement of Goods, Works, and Non Consulting Services under IBRD Loans and IDA Credits & Grants by World Bank Borrowers, dated January 2011, and Guidelines: Selection and Employment of Consultants under IBRD Loans and IDA Credits & Grants by World Bank Borrowers, dated January 2011, Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants, dated October 15, 2006 and revised in January 2011 and provisions stipulated in the Financing Agreement.

71. Public procurement in Tanzania is governed by the Tanzania Procurement Act, Act No. 21 of 2004. The Act has been reviewed by the World Bank and found to be satisfactory and consistent with Bank Procurement Guidelines, except the provisions of Clause 49 of the Act, which permits application of national preference in bid evaluation for national competitive bidding (NCB). Following the Act, the procurement function has been fully decentralized to procuring entities with the establishment of the Public Procurement Regulatory Authority (PPRA) as an oversight body for public procurement. Since its establishment in May 2005, PPRA has made tremendous progress toward building a robust procurement system, as recommended by the 2003 Country Procurement Assessment Report (CPAR).

72. The PPRA has developed various instruments for implementing the Act, including: (i) standard bidding documents for the procurement of goods, works, and non consultant services, as well as for the selection and employment of consultants; (ii) guidelines for use of the standard bidding documents; (iii) guidelines for preparing responsive bids and for evaluation of bids; (iv) a system for checking and monitoring procurement activities in the country and the development of performance indicators for the same; and (v) a Procurement Information Management System (PMIS). The major tasks of the PPRA at the national level are to (i) implement the above strategies and use the tools that have been developed; and (ii) implement other reforms that will ensure that the system is efficient, transparent, and deliver value for money.

73. Procurement capacity has been found to be the key constraint, especially at the local government level. Until now, PPRA has focused on building procurement capacity at the central government level; but it has now decided to shift its efforts toward building capacity at the local government level. This capacity building will be preceded by the establishment of the appropriate institutional framework required by the Procurement Act and the Local Government Procurement Regulations. With regard to this project, the procurement capacity of MoHSW and LGAs was assessed, and the findings and recommendations are included in Annex 3. The capacity assessment for MoHSW revealed that the MoHSW has sufficient staff to carry out procurement functions though the current staff members are not fully familiar with Bank's procurement procedures. The overall project procurement risk was assessed as ***High***, but with the mitigation measures outlined in Annex 3, the residual should be reduced to ***Moderate***. Substantial progress has already been made in this area.

E. Social (including safeguards)

74. By its nature, the HBF should disproportionately benefit more vulnerable members of society, including pregnant women and children. This is because these groups are currently exempted from user fees, so are more likely to access services if they are available. Moreover, the presence of the Basket funds, including specific funding for medicines and medical supplies, should improve the availability of services at the primary health care level. The proposed inclusion of performance elements in the allocation formula should promote efficiency, thereby ensuring that the maximum social benefit is obtained from the available resources. The emerging focus on equity considerations in terms of the geographic distribution of resources should also provide social benefits, since it should enhance the ability of those who are currently in under-resources areas to access necessary health care services. Finally, the creation of a multi-sectoral financing mechanism to support local service delivery should help to increase the overall level of funding going to the front lines with concomitant impact on access to services and service quality.

F. Environment (including safeguards)

75. The Borrower has implemented/is implementing 4 projects in the health and HIV-AIDS sectors so is well aware of safeguards requirements. The Ministry of Health and Social Welfare has recently updated the Health Care Waste Management (HCWM) Plan for another World Bank financed project in the area of public health laboratory upgrading. This plan is relevant and will be applicable for the management of medical care waste during the implementation of this project. The primary focus would be on the safe disposal of medical and laboratory wastes. MoHSW has also developed a National Action Plan (NAP) for implementing the HCWM for a period of five year (2009 – 2013). As part of the implementation of the NAP, the Project will finance several priority activities which were identified by the Ministry during appraisal. These will include assistance in the further development of the organizational and legal framework to support HCWM, efforts to standardize the HCWM practices and improve management and monitoring procedures, training and the provision of limited HCWM equipment.

76. The Basic Health Services Project would finance primarily operating costs, including medicines and medical supplies. Some Health Basket Funds may be used for minor works or renovations for existing facilities, but this would be done within the footprint of these facilities. The environmental management unit in MoHSW with support and oversight from National Environmental Management Council should continue to coordinate and supervise the implementation of the recently updated Health Care Waste Management Plan and the National Action Plan for HCWM. The HCWMP was disclosed prior to project appraisal.

Annex 1: Results Framework and Monitoring

TANZANIA: BASIC HEALTH SERVICES PROJECT
Results Framework

Project Development Objective (PDO): *Assist the Government of the United Republic of Tanzania in improving the equity of geographic access and use of basic health services across districts and enhancing the quality of health services being delivered.*

PDO Level Results Indicators*	Core	Unit of Measure	Baseline[3]	Cumulative Target Values**					Frequency	Data Source/ Methodology	Responsibility for Data Collection	Description (indicator definition etc.)
				YR 1	YR 2	YR3	YR 4					
Indicator One: Births attended in health facility broken down by LGA	☐	Percent	58.4%	60%	63%	66%	69%		Annual	HMIS (national and LGA level)	MoHSW	Total number of expected births divided by the number taking place in health facilities
Indicator Two: Average outpatient (OP) attendances per clinical staff member broken down by LGA[4]	☐	Number	1,395	1,395	1,450	1,500	1,600		Annual	HMIS (calculated, national and LGA level)	MoHSW	Total annual number of OP attendances divided by the number of clinical staff
Indicator Three: Average outpatient attendances per capita broken down by LGA	☐	Number	0.83	0.85	0.88	0.92	1.00		Annual	HMIS (national and LGA level)	MoHSW	Total annual number of OP attendances divided by population
Indicator Four: Health facilities with any stockouts of tracer medicines and vaccines according to CCHP	☐	Percent	28%[5]	25%	17%	10%	5%		Annual	HMIS (national and LGA level)	MoHSW	Number of facilities without any stock-outs divided by the total number of facilities
Indicator Five: Ratio of the 10 best performing LGA's to the 10 worst performing LGA's in indicators (1) through (3)	☐	Ratio	1: 8.1 2: 15.0 3: 8.0	no change	5% decrease	10% decrease	15% decrease		Annual	HMIS (calculated)	MoHSW	For each of indicators 1-3, divide the sum of the top 10 LGA values by the sum of the bottom 10 LGA values
INTERMEDIATE RESULTS												
Intermediate Result (Component One): Support to Local Government Service Delivery												
Intermediate Result indicator One: Children immunized	X	Number	0	1,457,280	2,965,564	4,526,637	6,142,347		Annual	HMIS	MoHSW	

[3] Baselines are national figures but monitoring will also be undertaken at the LGA level
[4] Final results will be dependent on interaction of increased use of services (indicator 3) and increased staffing levels (increase of 6,500 projected)
[5] Data as of August, 2011

Intermediate Result indicator Two: Children receiving a dose of Vitamin A	X	Number	0	6,864,916	13,976,968	21,345,053	28,978,389		Annual	HMIS	MoHSW	
Intermediate Result indicator Three: Direct project beneficiaries (of which female)	X	Number %	0 0	8,861,298 50.7	17,995,898 50.6	27,412,229 50.5	37,118,980 50.5		Annual	HBF (calculated)	MoHSW and NBS	IDA contribution as a percentage of the HBF times the estimated population from NBS, percent of women in the total population
Intermediate Result indicator Four: Pregnant women receiving antenatal care during a visit to a health provider	X	Number	0	1,542,740	3,135,635	4,778,685	6,471,889		Annual	HMIS and TDHS	MoHSW and NBS	Annual estimates from HMIS using NBS population estimates, verified by new TDHS (2015)
Intermediate Result indicator Five: Health centres in each LGA that provide emergency obstetrical care (EMOC)	☐	Percent	Hospitals 64.5%, Health Centers: 5.5%	no change	5% increase	10% increase	20% increase		Annual	HMIS (national and LGA level)	MoHSW	Number of facilities providing EMOC divided by the total number of facilities
Intermediate Result indicator Six: District Readiness for Service Delivery (composite indicator)	☐	Score	TBD, availdable December 31, 2012	no change	5% increase	10% increase	20% increase		Annual (if mainstreamed, otherwise Periodic)	HMIS (if mainstreamed, otherwise Special Study)	MoHSW	Composite score of service readiness across a number of measures (staffing, training, medicine, lab test, equipment and guidelines). Baseline carried out by special study; will try to mainstream into regular data collection.
Intermediate Result indicator Seven: Use of performance and equity indicators in LGA allocations and use of the approach developed under this project for service delivery grants in other sectors	☐	Degree	None	Partial – at least one performanc e or equity indicator is used	Partial – some perform-ance and equity indicators used	Partial – perform-ance and equity indicators agreed	Use of SDG approach by other sectors		Annual and End of Project	Review of allocation formula	Project team	Degree to which interventions have been accepted and expanded to other sectors
Intermediate Result (Component Two): Capacity Building in Local Governments												
Intermediate Result indicator One: LGAs with unqualified audit reports	☐	Percent	32% (44/136)	36%	40%	44%	48%		Annual	Annual Audit	CAG	Number of LGA audits with unqualified (clean) opinions divided by the total number of LGAs
Intermediate Result indicator Two: LGAs which have implemented the new DMIS system	☐	Percent	0%	10%	30%	50%	70%		Quarterly	M&E Project Tracking	M&E Project Team	Number of LGAs which have implemented the new M&E system (DMIS) divided by the total number of LGAs
Intermediate Result indicator Three: Council Health Service Boards (CHSBs) that meet on		Percent	60	63	69	75	86		Annual	CCHP reports	MoHSW	Number of LGAs which meet on a quarterly basis divided by the total number of LGAs

quarterly basis to discuss issues related to budget, CHF, rehabilitation, schedule of visits to lower facilities, staff houses etc.												
Intermediate Result indicator Four: LGAs which have implemented one or more community or social accountability mechanisms (score-card, posting financial or performance information, complaint line, enhanced community participation in health facility governance or public opinion survey)	☐	Percent	0%	0%	5%	10%	15%		Annual	Survey	PMO-RALG	Number of LGAs which have implemented such mechanisms divided by the total number of LGAs
Intermediate Result (Component Three): Central Programs to Support Local Service Delivery												
Intermediate Result indicator One: Health personnel receiving training	X	Number	0	5,775	12,400	19,300	25,500		Annual	HMIS	MoHSW	The total number of students enrolled in health institutes
Intermediate Result indicator Two: Regional Health Management Teams that have implemented performance monitoring and verification initiatives	☐	Percent	0%	0%	10%	20%	35%		Annual	Direct observation survey of RHMT's by PMO-RALG	PMO-RALG	Number of RHMTs which have implemented such mechanisms divided by the total number of RHMTs

Annex 2: Detailed Project Description

77. The project would focus on transforming the current mechanism for Health Basket Fund allocations to districts from an unconditional grant to a performance-based and equity oriented allocation and further transforming it into a Service Delivery Grants (SDG) mechanism which would complement the CDG and CBG mechanisms already in place, and to integrate these grants into the overall local government support framework. This transition would take place over the life of the project, continuing the current approach in the early years of the project but gradually evolving into an SDG mechanism. In order to make this transition, the project would focus specifically on strengthening public financial management and monitoring and evaluation, as well as developing new funds flow mechanisms. As with other sectoral programs – such as ASDP and WSSP – participating partners, including the World Bank, would continue to be involved in both the LGDG Steering Committee and sector-specific working groups or committees. This is essential to ensure to both the sectoral and LGA linkages are maintained.

78. The project would run for four years, covering the evolution of the health basket fund from its current form into a more performance-based mechanism, as well as the evolution from a health-only basket to a multi-sectoral Service Delivery Grant mechanism. It would include $20 million per year to the district health basket, plus $20 million to for institutional strengthening, including $5 million through the central basket. It is expected that the new mechanism would be operational in the final year of the project, although this would depend on discussions with other stakeholders and the pace of institutional strengthening initiatives. The project would have three components with the following structure:

79. *Component 1 – Support to Local Government Service Delivery* (indicative cost $80 million) – will finance annual per capita grants to LGA's of approximately $0.30 per person per year to support service delivery at the district level, including support for private not-for-profit and faith-based providers (FBO's) where they are providing health services on behalf of the Government. This Component will also fund medical supplies, medicines, vaccines and contraceptive commodities which will be procured centrally and used at the district level.

80. This component would have two subcomponents as follows:

81. *Subcomponent 1(a) – Direct grant to LGA's* (indicative cost $57 million) – this would be an annual grant equivalent to $0.30 per capita. In the first year of project implementation, this grant would be allocated to districts using the current funding formula, which currently takes into account the following four factors: population-70 percent, poverty head count-10 percent, district vehicle route-10 percent and under five mortality-10 percent. In subsequent years, the individual district allocations would be modified based on their performance and on equity considerations. The specific conditions would be developed and evolve over the life of the project based on multi-stakeholder discussions, including the MoHSW, PMO-RALG, representatives of LGA's, DP's and other stakeholders. These conditions would include (i) the effectiveness and efficiency with which existing funding is used, (ii) achievement of performance objectives, and (iii) variations in per capita health allocations (both staffing and operating costs). The annual amount of the grant would be set in consultation with the Basket Financing Committee to ensure consistency with DPs who prefer to continue to utilize the current Health Basket arrangement, although it would be expected that over time, most DP's

would migrate to the new arrangement.

82. *Sub-Component 1(b) – Basket Fund Grants for Medicines and Medical Supplies* (indicative cost $23 million) – this sub-component would provide an annual grant to the Central Basket Fund to finance the procurement of medicines and medical supplies by the Medical Stores Department (MSD). The exact nature of the medicines and medical supplies to be procured will be agreed annually between the MoHSW and the Basket Fund Partners.

83. *Component 2 – Capacity Building in Local Governments* (indicative cost $11 million) – provides funding through the CBG mechanism for those councils whose Capacity Building Plan contains specific reference to improving the capacity of local governments to manage their health services, and through centrally managed non-pooled interventions to further support this process. With respect to the CBG grants, the MoHSW and PMO-RALG would be fully engaged the dialogue and developing the criteria and mechanisms for the development, evaluation and distribution of funds for health related CBGs. Since the CBG mechanism is new, the use and distribution of funds between CBG and centrally management mechanisms would be reviewed and revised during project implementation based on experience with each approach. This component would finance technical assistance, training and systems strengthening interventions and will have three sub-components:

84. *Sub-Component 2(a) – Improved Public Financial Management at the Local Level* (indicative cost $5 million) – this sub-component will focus on improving public financial management (PFM) at local levels, including health sector institutions and related LGA and regional oversight structures. These PFM funds would complement those already committed to the Public Financial Management Reform Program (PFMRP), and the allocation of the funds would be based on discussions with the PFMRP team. In addition to CBG grants to LGA's to finance PFM improvements, there would also be central level funding to support the creation of zonal financial management support teams, and to develop improvements in budgeting, planning, and financial reporting.

85. *Sub-Component 2(b) – Strengthen Local Level Monitoring and Evaluation Systems* (indicative cost $3 million) – this sub-component will focus on strengthening monitoring and evaluation (M&E)/HMIS systems at the local level, including the regions, LGA's and health service providers. M&E funds would be channeled through the CBG mechanism and through centrally managed interventions in a way which complements the existing M&E Strengthening Initiative, which is already supported by a number of development partners, including the Global Fund, the Netherlands, and Norway.

86. *Sub-Component 2(c) – Improve Local Level Management and Accountability* (indicative cost $3 million) – this sub-component will seek to improve the overall management and accountability systems and procedures at the local level, including general facility management, human resources management, procurement and governance and accountability mechanisms (including social accountability). The funds for this sub-component will be distributed through both the Capacity Building Grant structure and through centrally managed interventions aimed at improved management capacity of District Health Management teams. The specific emphasis and priorities for these grants will be assessed and adjustments will be made throughout the life of the project, and appropriate adjustments will be made in the guidelines and criteria for these

grants as the requirements change. Social accountability mechanisms that will be promoted through the project would include the introduction of community scorecards, bulletin boards, complaints mechanisms and other means to increase public participation and strengthen public oversight.

87. *Component 3 – Central Programs to Support Local Service Delivery* (indicative cost $9 million) – as part of the overall health system, the MoHSW, PMO-RALG and the regions have important roles to play in effective local service delivery. It would include the following sub-components:

88. *Sub-component 3(a) – Basket Funding for Central Program Support* (indicative cost $5 million) – this sub-component provides funding through the Health Basket for central level interventions (particularly support for training), central level PFM and M&E initiatives, technical assistance for development of central level initiatives including guidelines, formats, and operational tools, management guidance (field visits and meetings) through PMO-RALG and the Regional Health Management Teams (RHMTs), various initiatives to support the performance management process (verification, promoting social accountability mechanisms) at the central and regional levels, and strengthening of a central level oversight structure.. The exact distribution of the funds in this sub-component will be adjusted over the life of the project to accommodate changing priorities and funding from various stakeholders, including the MoHSW, PMO-RALG, the regions and Development Partners.

89. *Sub-component 3(b) – Non-Basket Funding for Central Project Support and Evaluation* (indicative cost $3.5 million) – this sub-component provides funding and various central initiatives to support: (a) technical assistance, training and other support to improve the development and implementation of Comprehensive Council Health Plans; (b) technical assistance to develop independent data verification approaches and promote social accountability mechanisms for an enhanced performance management process; (c) an impact evaluation of the introduction of performance and equity indicators to the Allocation Formula; (d) an external evaluation of the HSSP III (along with other development partners); (e) carrying out an independent audit to assess the performance of the LGAs; and, (f) other interventions developed during the life of the project which will enhance the overall implementation of the Health Sector Strategic Plan III and the Project..

90. *Sub-component 3(c) – Non-Basket Funding to Support the National Action Plan for Health Care Waste Management* (indicative cost $0.5 million) – this sub-component will provide funding to support priority interventions in the National Action Plan to help improve the overall status of HCWM in Tanzania. These will include assistance in the further development of the organizational and legal framework to support HCWM, efforts to standardize the HCWM practices and improve management and monitoring procedures, training and the provision of limited HCWM equipment.

Annex 3: Implementation Arrangements

Project Administration

91. The project would be jointly managed between the MoHSW and PMO-RALG, using existing institutional arrangements. The project director will be a senior manager within the Ministry of Health and Social Welfare, who will be responsible for the implementation of all components. A senior person in PMO-RALG will also be appointed to interact with the project team in the MoHSW and the Bank team. Financial management will be done through the office of the Chief Accountant of the MoHSW and PMO-RALG, and procurement would be done by the procurement management unit. The key implementing agencies, including the MoHSW and PMO-RALG, are all very experienced in various pooled financing arrangements and should be able to adapt to these new approaches relatively quickly, since they largely utilize existing mechanisms and structures. It is not expected that any new structures will be required to support this project, although specific procedures will be needed within existing structures to deal with service delivery (operating) versus capital issues, and explicitly evaluate Capacity Building Plans to identify health related priorities.

92. These institutional arrangements are the same as have been used for the previous project, and reflect the agreed approach for the Bank's engagement in the health sector. Owing to the nature of the intervention, there will also be strong interaction with the Health Development Partners Group, and especially those partners contributing to the Health Basket Fund.

Financial Management

93. The project will be mainstreamed within GoT operations managed within the existing set-up in the MoHSW, PMO-RALG and LGAs. The Permanent Secretary of the two ministries will takes full fiduciary responsibility as the accounting officers while the day-to-day financial management transactions will be processed by the Chief Accountants of the MoHSW and PMO-RALG .

94. The project financial management unit within MoHSW and PMO-RALG will be responsible for the overall coordination and consolidation of financial management, auditing and disbursement information and submission of quarterly IFRs and withdrawal applications to the WB.

95. Both MoHSW and PMO-RALG have experience in implementing IDA projects and are currently the implementing agency of the Health Sector Project II, and LGSP-I, and Tanzania Strategic Cities Project (TSCP) respectively. These projects use government systems for budgeting, disbursement through exchequer system, accounting, internal and external audit, reporting, and oversight mechanism. The National Audit Office will carry out the external audit and audits will be submitted to the WB within six month after end of the FY.

Disbursements

96. **Disbursement Method:** The Project shall adopt the report-based method of disbursement by use of quarterly IFRs for non-pooled expenditures, and annual disbursements to the holding account for pooled expenditures, in accordance with the Health Basket Fund Memorandum of Understanding and the annual Side Agreement.

97. **Funds Flow Arrangements:** For non-pooled expenditures, the MoHSW and PMO-RALG will submit withdrawal applications to the Bank with six months cash flow forecasts based on agreed work plans and budgets. Funds for pooled expenditures will be deposited directly to the holding account, and accounted for as advances to a separate special account.

Procurement

98. The overall responsibility for procurement of works and goods (with the exception of medicines and medical supplies) and selection of consultants will be of the Ministry of Health and Social Welfare (MoHSW) through its Procurement Management Unit (PMU). Procurement of medicines and medical supplies is performed by Medical Stores Department (MSD), which is a semi-autonomous body under the MoHSW. Planning of the various activities will be coordinated by the Director of Policy and Planning Division under the HSRS which has also been responsible for the day to day activities of other Bank financed projects.

99. Procurement activities will be carried out by PMU of the MoHSW. According to the PPA 2004, every Procuring Entity is required to establish a PMU to manage all procurement and disposal activities except adjudication and award of contracts. The PMU has been established in accordance with the PPA 2004 and is headed by a Principal Supplies Officer (PSO), assisted by one Principal Supplies Officer, two Senior Supplies Officers and eighteen Supplies Officers of different grades, most of whom have limited experience in procurement and support staff including Assistant Supplies Officers, Supplies Assistants and secretaries. The PMU is also responsible for the procurement activities for the ongoing HSDP II financed by the Government and IDA. Procurement activities for this operation will also be undertaken by the same team, including the procurement of non-pooled goods and services, and the procurement related to pooled expenditures to the extent that they employ World Bank procedures.

100. An assessment of the capacity of the MoHSW to implement procurement actions for this project was carried out on May 31, 2011. The assessment reviewed the organizational structure, functions, staff skills and experiences, and adequacy for implementation of the project.

101. The key issues and risks concerning procurement for implementation of the project have been identified and mitigation measures proposed. The assessment found that MoHSW has some experience in the procurement of goods through ICB procedures. The ministry has however limited experience in the procurement works as well as in selection of large value consultancy contracts. In addition, the staff in the ministry would need training so as to enhance their skills in contract management.

102. The overall project procurement risk is assessed as ***High*** with mitigation measures put in place to have a ***Moderate*** residual risk. The proposed actions to mitigate the risk are summarized in the following table. Substantial progress has already been made in these areas.

Risk	Action	Timeframe	Responsibility
Inadequate experience in procurement of works as well as in selection of large value consultancy contracts.	Key procurement staff to be trained in procurement of works as well as in selection of large value consultancy contracts.[6]	During implementation of the project.	Borrower and IDA
Inadequate procurement planning.	Prepare a draft procurement plan for the first 18 months.	Completed.	Borrower
Inadequate procurement filing and record keeping.	Train staff in data management and establish acceptable procurement filing and record keeping system.	Within six months of implementation of the project.	Borrower
Inadequate knowledge in contract management	Train staff in contract management	During implementation of the project.	Borrower and IDA

Details of the Procurement Arrangements Involving International Competitive Bidding and Other Methods

Works, Goods and Non Consulting Services

103. List of contract packages to be procured following ICB / direct contracting and other methods:

1	2	3	4	5	6	7	8	9
Ref. No.	Contract Description	Estimated Cost ($'000)	Procurement Method	Prequal (yes/no)	Domestic Preference (yes/no)	Review by Bank (Prior / Post)	Expected Bid-Opening Date	Com-ments
1	Procurement of Motor Vehicles	470,0	NCB	NA	No	Post	February, 2012	
2	Supply of ICT Equipment	41.5	Shopping	NA	No	Post	February, 2012	
3	Printing of Guidelines and Operations tools for ZHRC	20.0	Shopping	NA	No	Post	February, 2012	
4	Printing of Training and Tutorial Materials for training of 8 zones	9.0	Shopping	NA	No	Post	February, 2012	

104. ICB contracts for goods estimated to cost above US $ 500,000 equivalent per contract and all direct contracting will be subject to prior review by the Bank. However, a specified number of NCB contracts identified in the Procurement Plan shall be prior reviewed.

Consulting Services

[6] Training of LGA staff in procurement will be possible through the Capacity Building Grants (Component 2)

105. List of consulting assignments with short-list of international firms and other selection methods

1	2	3	4	5	6	7
Ref. No.	**Contract Description**	**Estimated Cost** ($'000)	**Selection Method**	**Review by Bank (Prior / Post)**	**Expected Proposals Submission Date**	**Comments**
1 2(a)	Individual Consultants to Provide Technical Support to Zonal Financial Management	1,404.0	IC	Prior	February, 2012	
2 2(a)	Individual Consultants to Provide Technical Support to Hospital Financial Management	819.0	IC	Prior	February, 2012	
3 2(a)	Individual Consultants to Provide Technical Support on Budgeting, Planning and Financial Reporting	420.0	IC	Prior	February, 2012	
4 3(b)	Individual Consultants to Provide Technical Assistance on Regional M & E Advisory	428.0	IC	Prior	February, 2012	
5 3(b)	Individual Consultants for Provision of Technical Assistance to CCHP support	785.8	IC	Prior	February, 2012	
6 3(c)	Individual Consultant to Provide Technical support for the development of a plan for the management of HCW in all secondary and tertiary health facilities including recycling	50.0	IC	Post	February, 2012	
7 3(c)	Provision of Consultancy Services for Preparation of National Regulations for Hospital Hygiene, and Infection Control and Safe Management of Health - Care Wastes	70.0	CQ	Post	June, 2012	

106. Consultancy services estimated to cost above US$ 300,000 equivalent per contract and single source selection of consultants (firms) will be subject to prior review by the Bank. Consultancy services estimated to cost above US$ 100,000 equivalent per contract for individual consultants will be subject to prior review by the Bank in exceptional cases only, e.g. when hiring consultants for long-term technical assistance or advisory services for the duration of the project.

107. **Short lists composed entirely of national consultants**: Short lists of consultants for services estimated to cost less than US$200,000 equivalent per contract may be composed entirely of national consultants in accordance with the provisions of paragraph 2.7 of the Consultant Guidelines.

Advertising

108. All works and goods contracts to be procured under ICB and consultancy services contracts estimated to cost US $ 200,000 and more equivalent per contract shall be advertised in UNDB online and dgMarket in addition to advertising in national news paper(s) of wide circulation.

Thresholds for Procurement Methods and Prior Review

109. Thresholds for procurement methods and for prior review are presented in the table below.

Expenditure Category	Contract Value Threshold (US$)	Procurement / Selection Method	Contracts Subject to Prior Review
Works	≥5,000,000	ICB	All
	<5,000,000	NCB	None (Post review) unless specified in the PP
	<50,000	Shopping	None (Post review)
	All values	Direct Contracting	All
Goods	≥500,000	ICB	All
	<500,000	NCB	None (Post review) unless specified in the PP
	<50,000	Shopping	None (Post review)
	All values	Direct Contracting	All
Consulting Services - Firms	≥ 300,000	QCBS/ Other (QBS/FBS/LCS)	All
	< 300,000	CQS/ Other (QBS/FBS/LCS)	None (Post Review)
	All values	SSS	All
Consulting Services – Individuals (IC)	≥100,000	IC - Qualification	All
	<100,000	IC - Qualification	None (Post review)
	All Values	IC - SSS	All

110. Terms of Reference for all contracts will be cleared by the Bank.

Environmental and Safeguards

111. The Borrower has implemented/is implementing 4 projects in the health and HIV-AIDS sectors so is well aware of safeguards requirements. The MoHSW has also recently updated the Health Care Waste Management Plan (HCWMP) for another World Bank financed project in the area of public health laboratory upgrading. The project would finance primarily operating costs, including medicines and medical supplies. Some Health Basket Funds may be used for minor works or renovations of existing facilities, but this would be done within the footprint of these facilities.

112. No additional studies were needed to meet environmental and safeguards requirements, since the HCWMP was just updated for the regional laboratory project. The primary focus of the environmental measures would be on the safe disposal of medical and laboratory wastes. The environmental management unit in MoHSW with support and oversight from National Environmental Management Council should continue to coordinate and supervise the implementation of the recently updated Health Care Waste Management Plan and Checklist version EMP.

Monitoring and Evaluation

113. Over half of the indicators for the project, including four of the five PDO indicators, will come from the existing Health Management Information System, and are mostly standard and agreed indicators which are in the HSSP III. Several others will come from the monitoring of other projects, of existing CAG processes. The remaining three indicators will be obtained through a relatively simple annual assessment of progress at the national, regional and LGA level. Since most of the indicators will come from existing systems or processes, adequate capacity exists to collect them. Furthermore, further strengthening of the M&E system will be partly financed through the project. No additional costs are expected in order to collect this data.

114. During project implementation, the M&E data will be used to determine if the interventions supported by the project are having the expected impact, especially in the areas of improved LGA performance and reduced variation in the allocation of resources. Should the progress be less than expected, further analysis will be undertaken to determine the source of the problem and corrective action will be taken.

115. In addition to the specific indicators in the results framework, the team will continue to monitor overall progress in the health sector, using the full set of agreed M&E indicators for HSSP III, and the various instruments that have been put in place as part of the overall sector dialogue structure, including (i) the Annual Health Sector Performance Profile Report which tracks , (ii) annual Public Expenditure Reviews, (iii) annual financial audits by the National Audit Office, (iv) annual and procurement reviews by the Public Procurement Regulatory Authority, (v) periodic National Health Accounts studies, and (iv) periodic external evaluations. The overall SWAp dialogue structure with regular meetings to discuss key issues and sector developments, and an established forum for DP engagement and coordination, will also be used to ensure that the Bank stays engaged in policy discussions during project implementation and makes appropriate changes to project interventions as needed to reflect sector developments.

Role of Partners

116. At the present time there are 17 development partners active in the health sector in Tanzania, and 11 of these contribute to the Health Basket Fund. The current contributors are: Ireland, the Netherlands, Germany, Switzerland, Canada, Denmark, Norway, UN, UNFPA, UNICEF and IDA. The Netherlands has announced that it will be leaving Tanzania in the next year or so, but Canada has announced a significant increase in its HBF contribution. Both the UK and Australia have signalled that they will be entering the health sector, but there has been no indication to date that either will join the HBF. A detailed explanation of the dialogue structure in health is shown in Annex 7.

117. The HBF process includes regular meetings between the contributing DP's, GoT and other stakeholders to discuss the use of basket funds in a "Basket Financing Committee". The overall relationship between the BF DP's and the GoT is governed by a Memorandum of Understanding, signed by all the parties, and each year a "Side Agreement" is signed which outlines the specific agreements with regard to the amounts to be contributed and the manner in which these amounts are to used. Specific allocations are highlighted for LGA's (based on an overall amount per capita), regions and PMO-RALG for supportive supervision, and the central basket. Discussions also take place regarding the distribution of the central basket amount, in terms of allocations for medicines and medical supplies, training, SWAp operations and other items.

Annex 4
Operational Risk Assessment Framework (ORAF)

UNITED REPUBLIC OF TANZANIA
Basic Health Services Project

Project Stakeholder Risks	**Rating**	**Moderate**		
Description: The risk is that the new approach proposed (using performance and equity indicators and evolving into a SDG mechanism) will be opposed by the Government or some development partners. However, the Government and DPs have been promoting increased alignment and harmonization and the innovation promoted by this project would contribute to this result so this risk is considered moderate.	**Risk Management:** Significant consultation with Government and Donors during project preparation			
	Resp: Bank	**Stage:** Preparation	**Due Date:** June 2011	**Status:** Completed
	Risk Management: Ongoing consultation throughout implementation process, including the mechanisms for integrating the SDG's into the overall LGSP process			
	Resp: Client	**Stage:** Implementation	**Due Date:** Jun 2015	**Status:** Not yet due
	Risk Management : Ability to continue using the existing financing mechanism (the Health Basket Fund) while discussions on changes to the financing mechanism are ongoing.			
	Resp: Bank	**Stage:** Implementation	**Due Date:** Jun 2015	**Status:** In progress
Implementing Agency Risks (including fiduciary)				
Capacity	**Rating:**	**Substantial**		
Description: Although MoHSW and PMO-RALG have adequate capacity and experience in managing IDA projects, weak financial management capacity at LGAs and possible misuse of funds as highlighted in the FM review pose a challenge since majority of funds and activities will be implemented at LGAs level. Audit opinions are improving but systems have not yet progressed to the point that risks can be considered low.	**Risk Management:** Part of the funds for component 2 and 3 will focus on improving PFM issues including technical assistance to strengthen health sector institutions and related LGAs and regional oversight structures. There is also ongoing PFM reforms in the two ministries and LGAs supported by current PFMRP.			
	Resp: Client	**Stage:** Implementation	**Due Date:** Jun 2015	**Status:** In progress
	Risk Management: Agreed format of IFRs at all levels			
	Resp: Client	**Stage:** Preparation	**Due Date:**	**Status:** Completed
	Risk Management: Expansion of the scope of external audit to include performance and social audits			
	Resp: Client	**Stage:** Implementation	**Due Date:** Jun 2015	**Status:** Not yet due
	Risk Management: Designation of project accountants with experience in managing IDA funds at MOHWS and PMO-RALG to provide regular FM oversight			
	Resp: Client	**Stage:** Preparation	**Due Date:**	**Status:** Completed
	Risk Management: Disclosure of information on financing and support to community			

	monitoring of expenditures			
	Resp: Client	**Stage:** Implementation	**Due Date:** Jun 2103	**Status:** Not yet due
	Risk Management: Regular FM supervision and review of periodic project financial performance, annual financial statements by the WB – FMS			
	Resp: Bank	**Stage:** Implementation	**Due Date:** Jun 2015	**Status:** Not yet due
	Risk Management: Instituting effective internal and external audit functions using a risk-based framework			
	Resp: Client	**Stage:** Implementation	**Due Date:** Jun 2014	**Status:** Not yet due
Governance	**Rating:**	**Substantial**		
Description: There is a risk that the funds allocated will not be used for the intended purpose (i.e., allocated to other sectors).	**Risk Management:** M&E systems will be strengthened through MESI as part of the run-up to implementation of the SDG			
	Resp: Client	**Stage:** Implementation	**Due Date:** Jun 2013	**Status:** Not yet due
	Risk Management: Regular reporting of the utilization and impact of SDG funds as well as annual (CAG) audits will be required			
	Resp: Client	**Stage:** Implementation	**Due Date:** Jun 2015	**Status:** Not yet due
	Risk Management : Independent verification mechanisms will be developed to verify the data reported for equity and performance indicators.			
	Resp: Client	**Stage:** Implementation	**Due Date:** Jun 2013	**Status:** Not yet due
Project Risks				
Design	**Rating:**	**Substantial**		
Description: There is a risk that the SDG approach will prove unworkable within the overall LGSP framework. However, the approach being pursued is similar to that already in place, with the exception that it focuses on ongoing operational versus capital expenditures. There is also a risk that there will be a failure to agree on indicators, an evaluation approach and/or the resource allocation formula.	**Risk Management:** Consultations with key stakeholders to determine the feasibility of this approach. Changes will be made incrementally over several years based on the consensus among stakeholders, with appropriate capacity building and consultation in advance.			
	Resp: Bank	**Stage:** Preparation/ Implementation	**Due Date:** Jun 2015	**Status:** In progress
	Risk Management: The BHSP results framework will remain the basis for the selection of indicators.			
	Resp: Client	**Stage:** Preparation	**Due Date :**	**Status:** Completed
Social & Environmental	**Rating:**	**Moderate**		
Description: There is a risk from the handling and disposal of medical waste, however the Borrower is well aware of safeguards requirements. The Basic Health Services Project would finance primarily operating costs, including medicines and medical supplies. Some Health Basket Funds	**Risk Management:** The MoHSW recently updated the Health Care Waste Management Plan for another project, and monitors this plan on an ongoing basis, providing progress reports to the Technical Committee of the SWAp.			
	Resp: Client	**Stage:** Implementation	**Due Date:** Jun 2015	**Status:** In progress

may be used for minor works or renovations for existing facilities, but this would be done within the footprint of these facilities.				
Program & Donor	**Rating:**	**Low**		
Description: The basic structures are being maintained, while the mechanisms to promote increasing harmonization of LGA financial flows. There may be some concerns from the relevant ministries and donors about how the interventions in this project fit within the overall health SWAp approach.	**Risk Management:** Extensive discussions have been and will continue to be held with both the relevant ministries and other DPs to ensure that potential issues are fully discussed and addressed. A full change to the new financing mechanism will not be made until the key stakeholders are comfortable with the new approach.			
	Resp: Client/Bank	**Stage:** Preparation/ Implementation	**Due Date:** Jun 2014	**Status:** In progress
Delivery Monitoring & Sustainability	**Rating:**	**Substantial**		
Description: Although there is still a long way to go, a culture of monitoring and ongoing reporting is beginning to emerge. There will be an ongoing need for external financing in these sectors, and there is a risk that the available funding for this initiative in various sectors will dry up as DPs move to other priorities. However, there is no current indication that there will be a major shift in DPs out of these sectors.	**Risk Management:** Progress will be measured through agreed indicators, which are part of the sector strategic plans. Independent verification mechanisms will be explored. Capacity building funds are included to improve the management of the funds received and the monitoring of results, benefiting the entire system.			
	Resp: Client	**Stage:** Implementation	**Due Date:** Jun 2015	**Status:** Not yet due
	Risk Management: Social accountability mechanisms such as community scorecards will be pursued to provide community and user input into results monitoring.			
	Resp: Client	**Stage:** Implementation	**Due Date:** Jun 2013	**Status:** Not yet due
	Risk Management: By demonstrating results with this approach and integrating the SDG into the overall local government support framework, the continuation of funding is more likely, compared to one-off initiatives, or approaches developed solely to handle World Bank assistance.			
	Resp: Bank	**Stage:** Implementation	**Due Date:** Jun 2015	**Status:** In progress

Overall Risk
Implementation Risk Rating: Substantial
Comments: The overall risk rating is substantial. There are basically two sets of risks. The first set center around the implementation of a new funding modality to support the ongoing operating costs of service delivery at the district level. The second set of risks reflect the realities of dealing with the LGA level in Tanzania, including issues of capacity, governance, and ensuring the actual achievement and monitoring of results. Given the level of engagement that has already taken place with the Government and other development partners, the capacity building measures being put in place and the nature of the intervention being proposed, there is a high level of confidence that these risks can be effectively managed, as outlined above.

Annex 5: Implementation Support Plan

118. The project will be managed from the field, and virtually all of the project team will also be based in the field. This will allow the implementation support to be carried out on an ongoing basis, using a combination of project-specific meetings as well as the regular policy dialogue processes as noted in Annex 3. Both financial management and procurement support will also be obtained from the country office, which will allow both regular, ongoing support and "just-in-time" assistance as issues come up. The major contracts under this project will be through the Health Basket Fund, following procedures specified in Annex 3.

119. Because of the nature of the project, implementation will be dynamic and will be tailored to the specific needs of the evolving policy situation in Tanzania. The level of both DP and MoHSW/PMO-RALG support will govern the transition to a more performance-oriented and equity-focused health basket fund mechanism. In this respect, there will be a great deal of flexibility in terms of getting toward the desired end result, but the focus will continue to be on this result throughout project implementation.

120. Since the Bank has had a long-standing relationship with the MoHSW and PMO-RALG, it is expected that this relationship will continue through project implementation and help to move the project towards its intended goals. In particular, the level of support within the two key implementing agencies for this approach should help to ensure that there will be an ongoing focus on the development objectives of this project.

121. The level and type of implementation support is shown in the attached table:

Skills Needed	Number of Staff Weeks	Number of Trips	Comments
Health system management, and health financing	8	2 (within Tanzania)	Assumes that the TTL has these skills
Local government administration and financing	3	2 (within Tanzania)	Assumes staff is based in Dar es Salaam
Public service management	3		Assumes staff is based in Dar es Salaam
Public financial management	3	2 (within Tanzania)	Assumes staff is based in Dar es Salaam
Monitoring and evaluation	3	2 (within Tanzania)	Assumes staff is based in Dar es Salaam

III. Partners

Name	Institution/Country	Role
See Annex 3 and 7		

Annex 6: Team Composition

World Bank staff and consultants who worked on the project:

Name	Title	Unit
Dominic S. Haazen	Lead Health Policy Specialist, Team Lead	AFTHE
Emmanuel Malangalila	Senior Health Specialist (retiree consultant)	AFTHE
Arun Joshi	Senior Education Specialist	AFTED
Denis Biseko	Senior Public Sector Specialist	AFTPR
Sanjeev Ahluwalia	Senior Public Sector Specialist	AFTPR
Jane Kibbassa	Senior Environment Specialist	AFTEN
Helen Shahriari	Senior Social Scientist	AFTCS
Mercy Mataro Sabai	Senior Financial Management Specialist	AFTFM
Donald Mneney	Senior Procurement Specialist	AFTPS
Maryam Salum Ahmed		AFCE1

Annex 7: Country and Sector Background

The Tanzanian Economy and Poverty Reduction[7]

122. Tanzania experienced economic growth of between 5 and 7 percent per annum during the period from 2000 to 2008, until the global financial crisis hit the economy in 2009 (Table A7.1). Sustained economic reforms and macroeconomic stability, coupled with a favorable external environment, contributed to this growth. While the Government carried out an expansionary fiscal policy since 2000 with a fast rise in government expenditures, the fiscal environment was overall on a prudent track, sustained by strong growth in tax revenues, large debt relief, and significant growth in foreign aid. Inflation was initially kept in check but accelerated starting in 2005, reaching double digits in 2008, driven by adverse regional food supply shocks and challenges in managing large liquidity coming from public and private capital flows. The real effective exchange rate converged to a more competitive level after being overvalued at the beginning of the decade, but has started to appreciate again in real terms, mainly due to higher domestic inflation.

Table A7.1: Key Economic Indicators

			Actual		Estimated		Projected		
	2005	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
GDP (US$ million at current prices)	14,251	14,797	17,305	19,017	21,628	24,756	28,388	32,753	36,471
GNI Per Capita (US$, Atlas method)	378	383	387	442	460	475	490	510	550
Output and Prices									
GDP growth (%)	7.4	6.7	7.1	7.4	6.0	7.0	6.8	7.5	7.8
Annual inflation (% CPI, end of year)	5.0	7.2	7.0	10.3	12.1	5.5	9.0	8.5	7.5
Exchange and Interest Rates									
Exchange rate** (T Sh per USD)	1,165	1,261	1,132	1,280	1,320	1,440			
	FY05/ 06	**FY06/ 07**	**FY07/ 08**	**FY08/ 09**	**FY09/ 10**	**FY10/ 11**	**FY11/ 12**	**FY12/ 13**	**FY13/ 14**
Fiscal Developments									
Domestic Revenue to GDP	12.4	14.1	15.9	16.2	15.2	16.1	16.3	16.5	16.7
Overall budget balance to GDP (after grants)	-4.8	-4.9	-1,7	-4.5	-6.4	-6.5	-6.0	-5.2	-4.1
Domestic borrowing to GDP	1.5	1.2	-1.5	1.0	1.8	1.0	1.0	1.0	1.0

Source: CAS 2011, pp. 7, 58, 59, and GoT Macroeconomic Framework Paper.

123. The global financial and economic crisis has led to a growth slowdown in Tanzania. Real GDP growth in 2009 is estimated to have dropped to around 6 percent from 7.4 percent in 2008. The crisis has affected Tanzania through the export channel—mainly tourism, cash crops, and regional manufacturing exports—and by lower capital flows: foreign assistance and private investment flows. Manufacturing, wholesale and retail trade, transport, communication services, and construction were the most affected sectors. GDP growth increased to 7.0 percent in 2010 and is expected to remain stable in 2011 and then exceed 7 percent starting in 2012.

[7] Largely based on the Tanzania Country Assistant Strategy (World Bank, 2011)

124. Annual inflation exceeded 12 percent in 2009, but dropped to an estimated 5.5 percent in 2010.. Despite the solid growth record, findings from the recent analysis based on the 2007 Household Budget Survey (HBS) pose a mixed picture of the country's progress in poverty reduction over the past eight years. Lower relative prices from imported goods and increased government spending led to tangible improvements in some areas, including ownership of consumer durables, housing quality, and some social indicators such as under-five mortality and enrollment in primary education. On the other hand, progress was rather limited in terms of basic-needs income poverty, ownership of productive assets in rural areas, as well as some other social indicators, such as maternal mortality or access to safe water.

125. Between 2001 and 2007, income-poverty incidence fell slightly in mainland Tanzania, as did the depth and intensity of poverty. However, the size of these decreases is small. Per capita consumption measured through the HBS increased by only 5 percent in real terms in the period between 2000–1 and 2007. With such a small change in consumption, the poverty head-count ratio dropped only slightly, from 35.6 in 2001 to 33.6 in 2007. As the head count fell by little while the population continued to grow rapidly, the absolute number of poor people increased by 1.3 million in the period. In rural areas, the change in poverty was not statistically significant. Even though relative inequality remained more or less unchanged, consumption declined for a small fraction of households at the very bottom of the income distribution. There was also a marked urban-rural gradient in poverty incidence, with the poverty head-count ratio in Dar es Salaam calculated at 16.4, compared to 24.1 in other urban areas and 37.6 in rural parts of Tanzania.

Population Dynamics and Demographic Changes

126. Changes in population numbers and demographics are important because they indicate the changing requirements for various types of services and infrastructure even if there is little or no change in living standards. With a population of approximately 43 million in 2010, Tanzania is the 7th most populous country in Africa. At 2.9%, the annual population growth rate is high, and projected to remain high into the foreseeable future, dropping only to 2.73% by 2025. According to the National Bureau of Statistics Population Projection (NBOS), this relatively stable population growth rate is the result of both a significant decline in the Total Fertility Rate (TFR), from 5.1 to 3.4, as well as a reduction in the crude death rate, from 13.3 to 9.7. The expected decline in the infant and under 5 mortality rates contribute to the overall decline in the death rate.

127. Despite the expected decline in the TFR, the significant (almost 50%) increase in the number of women of child-bearing age means that the total number of babies born each year will remain more or less constant over the projection period. As a result of these dynamics, Tanzania's total population is projected to almost double from 33.7 million in 2000 to 65.3 million by 2025.

128. This projection is important for policy making and the planning for future health financing options, since the size and structure of the population has an impact on what might be feasible. Table A7.2 shows the historical and potential future characteristics of the population. It should be noted that the figures from 2010 onward are projections, which differ from the actual figures noted earlier from the recently completed 2010 DHS.

Table A7.2: Population and Demographic Indicators and Projections for Tanzania

	<---------- Historical --------->			<---------- NBS Projection ---------->			
	1960	1980	2000	2010	2015	2020	2025
Total Population (million)	10.26	18.67	33.71	43.19	49.86	57.10	65.34
Women 15-49	--	4.15	7.74	10.37	11.82	13.44	15.45
Percent	--	22.2%	23.0%	24.0%	23.7%	23.5%	23.6%
	--						
Children 0-14	--	8.78	15.48	19.17	22.23	25.27	28.18
Percent	--	47.0%	45.9%	44.4%	44.6%	44.3%	43.1%
Working age pop. 15-59	--	8.83	16.77	22.02	25.43	29.31	34.18
Percent	--	47.3%	49.7%	51.0%	51.0%	51.3%	52.3%
Older population 60+	--	1.06	1.46	2.00	2.20	2.52	2.97
Percent	--	5.7%	4.3%	4.6%	4.4%	4.4%	4.5%
Dependency ratios							
Young	--	0.99	0.92	0.87	0.87	0.86	0.82
Elderly	--	0.12	0.09	0.09	0.09	0.09	0.09
Total	--	1.11	1.01	0.96	0.96	0.95	0.91
Population Growth Rate	--	3.04%	3.00%	2.51%	2.92%	2.75%	2.73%
Number of Births ('000)	--	896.1	1,396.0	1,678.3	1,704.8	1,697.9	1,660.2
Number of Deaths ('000)	--	360.6	555.9	573.2	589.1	621.7	636.7
Crude Birth Rate	--	48.01	41.41	38.86	34.19	29.73	25.41
Crude Death Rate	--	19.32	16.49	13.27	11.81	10.89	9.74
Total Fertility Rate	--	6.84	5.74	5.10	4.50	3.90	3.40
Infant Mortality Rate	--	128.6	82.2	80.5	72.2	64.7	56.8
Life expectancy (years)	--	47.3	46.3	55.0	57.0	58.0	61.0

Sources: Historical -- U.S. Census Bureau International Database
Projection -- Tanzania National Bureau of Statistics

129. The impact of population growth on the need for infrastructure and staffing will be considerable since there are expected to be more than half again as many people by 2025, compared to 2010, to whom health services will need to be delivered. As will be seen below, the system is already having difficulty coping with the current service needs, so gearing up for such a large increase in just 15 years will be a significant challenge. It is worth noting that the relatively stable number of births projected from the NBS model means that the focus in the area of maternity and obstetrical care will need to be on ensuring that services are available for current levels of delivery, and that these services are in fact used.

130. Overall, there will be a slight decline in the dependency ratio, mostly as a result of a reduction in the percentage of young people in the overall population, as those currently under 15 years of age enter the workforce. Household size dropped from 5.7 in 1991/92 to 4.9 in 2001/02 and 4.8 in 2007. At an average of 5.1 adult equivalents in 2007, the household size in rural areas is considerably higher than in urban areas and the decline in size has not been as great, with an average of 5.9 in 1991/92. In contrast, there has been a continuing drop in household size in Dar es Salaam, from 4.6 in 1991/92 to 4.3 in 2000/01 and 3.7 in 2007, while the change in household size in other urban areas is not quite as dramatic, going from 4.9 in 1991/92 to 4.4 in 2007. Note that in these figures are taken from the 2007 Household Budget Survey and are expressed in terms of "adult equivalents", not just the number of family members. The percentage of female-headed households also increased considerably, going from 18% in 1991/92 to 23% in 2000/01 and 25% in 2007.

131. An important consideration is the degree to which jobs will be available for new workers. According to the Integrated Labor Force Survey (2006), labor force participation rates for both women and men are high (88.8% and 90.5% respectively), although there is a high degree of informality in the workforce, and a substantial proportion of the total workforce engaged in agriculture.

132. In 2006, 40% of all households engaged in informal sector activities, with the percentage reaching 57% in Dar es Salaam and 54-55% in urban areas[8]. The percentage in rural areas is 33%. Between 2001 and 2006, the level of informality decreased in urban areas, but increased in rural parts of Tanzania, increasing overall from 35% to 40%. The overall number of households estimated to engage in informal sector activities grew by 65%, from 2.0 million to 3.3 million households.

133. About three-quarters of all employed individuals work informally in agriculture and fisheries, with this proportion increasing to almost four-fifths for women and decreasing to 70% for men. Naturally, the proportion in rural areas is much higher than in the cities, 88% versus 43% in other urban areas and still 13% in Dar es Salaam[9]. An important consideration for any health financing option is the fact that the incomes of those engaged in agriculture are considerably lower than those in other occupations. For example, paid employees in agriculture, hunting and forestry have a mean monthly income of just TSH 39,731 (44,896 for males, 25,009 for females), while self-employed individuals in the same sector have a slightly better mean income of TSH 56,186 (67,457 for males, 43,896 for females), although they may also receive additional income in kind. Median incomes are even lower, at TSH 14,000 for paid employees and TSH 20,000 for self-employed workers[10]. The potential options for health financing, especially in terms of revenue generation, are severely constrained by such low levels of cash income for such a large proportion of the workforce.

[8] ILFS (2006), p. 43
[9] Ibid, p. 26
[10] Ibid, p. 82 and 85

Overview of the Health System in Tanzania

134. The Tanzanian health care system before trade and economic liberalization in the 1980s was solely in the hands of central government, financed through the national budget. There was some recognition of religious and other non-profit facilities which were financed through donations from their sponsoring institutions and some service fees from clients. These facilities were heavily concentrated in areas where government facilities were not well established, especially rural and remote areas of the country.

135. Mainland Tanzania is divided into 21 administrative regions and 113 districts with 133 Councils. There are a total of about 10,342 villages. Services are organized in a pyramidal structure with dispensaries and health centers at the base, and district hospitals, regional hospitals and national referral hospitals moving upwards towards the apex. There are both public and private providers operating dispensaries, health centers and at least one hospital at the district level. Currently there are 4,679 dispensaries and 481 health centers throughout the country. About 90% of population lives within five kilometers of a primary health facility.[11]

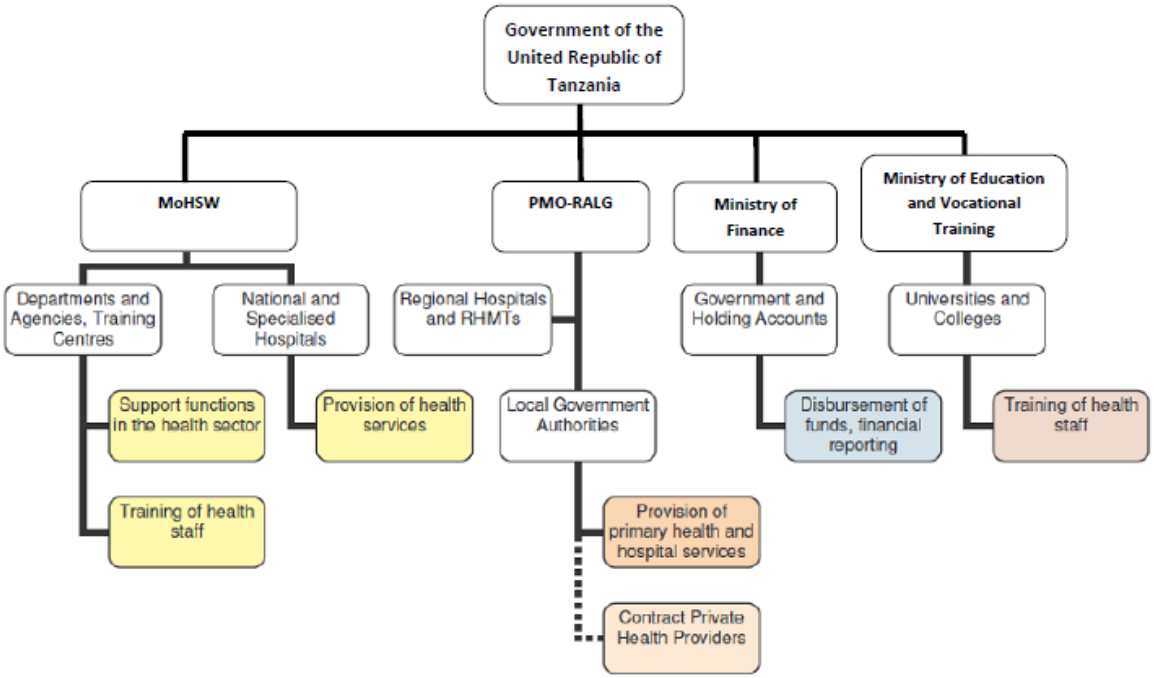
136. There are 55 district hospitals owned by Government and 13 Designated District Hospitals, owned by Faith Based Organizations (FBO). There are also 86 other hospitals at first referral level (owned by Government, parastatals and private sector), as well as 18 Regional Hospitals, functioning as referral hospitals for the relevant district hospitals and 8 consultancy and specialized hospitals in the country. According to Government staffing norms, only 35% of positions are filled with qualified health workers. While these staffing norms are currently being revised to take into account the increased density of health facilities under the Primary Health Care Development Program ("MMAM" in Kiswahili), there is no doubt that significant human resource shortages exist.

137. It is generally perceived that the quality of care in FBO facilities is relatively better than that of public facilities, although there is little empirical evidence to substantiate this perception. The government is revising its support to CSSC and other FBO's through formal Public-Private Partnership arrangements, including the introduction of service agreements which will specify contractual obligations in return for government funds.

138. The Tanzania Mainland health system is administered by the Ministry of Health and Social Welfare (MoHSW) – which provides overall policy direction and quality control, and runs regional and national referral hospitals – and the Prime Ministers' Office, Regional Administration and Local Government (PMO-RALG), which oversees the district system of district hospitals and primary health care centers and dispensaries. These facilities are owned and operated by Local Government Authorities (LGAs). The organization structure for the publicly financed health sector is shown in Figure A7.1 below (source HSSP III, p. 12).

[11] Health Sector Strategic Plan III (2009), p.11

Figure A7.1: Organization of the Health System in Tanzania



139. A series of Health Sector Strategic Plans (HSSP) have been produced to guide the development of the health system in Tanzania. The latest, HSSP III was launched by the President of Tanzania on June 30, 2009. It outlines 11 strategies and 6 cross-cutting issues which encompass the three main levels of care in the health sector (district, regional and national), and the 5 different types of services (dispensary, health center, district hospital, regional hospital and national hospital). The 11 strategies focus on the following areas:

- District Health Services
- Referral Hospital Services
- Central Support
- Human Resources for Health
- Health Care Financing
- Public Private Partnerships
- Maternal, Newborn and Child Health
- Disease Prevention and Control
- Emergency Preparedness and Response
- Social Welfare and Social Protection
- Monitoring & Evaluation and Research

140. The health care system is still run under the implicit assumption that a major part of the financing of health care facilities runs through the national budget (partly financed by taxes and partly by money from development partners). In fact, a significant portion of total health care financing comes from other than these sources. The proportion of total funding provided by development partners is also growing, both in terms of on-budget and off-budget financing. The largest portion of the off-budget financing is for HIV/AIDS and malaria programming.

Sector Wide Approach (SWAp) and Dialogue Structure

141. The Sector Wide Approach (SWAp), initiated in 1999 in the health sector in Tanzania, provides the framework of collaboration among the stakeholders, MoHSW, PMO-RALG, MoF, civil society, private sector and DPs. It coordinates financing, planning, and monitoring mechanisms and therefore aims at creating synergies, while reducing transaction costs. Central in the SWAp is the implementation of health policies and the HSSP.

142. The *Development Partners Group for Health (DPG Health)* is a collection of 17 bilateral and multi-lateral agencies supporting the health sector in Tanzania. Funds are provided through general budget support, the health basket, projects, and technical assistance. Leadership of the DPG-Health is conducted in form of a troika (3 person lead arrangement with one incoming chair, one chair and one outgoing chair). Meetings between the DPs and the GoT take place as defined in the SWAp arrangement.

Code of Conduct

143. The MoHSW, PMO-RALG, the Ministry of Finance (MoF) and DPs in the health sector agreed a Code of Conduct for the SWAp in the health sector Tanzania. The first Code of Practice was signed in 2003 and in 2007 the new Code of Conduct was signed. The Code of Conduct is based in the JAST. It aims at increasing transparency, improved predictability and allocation of financing, reduced transaction costs and reduced administrative demands placed upon government. The Code of Conduct describes the sectoral dialogue and coordination, planning and budgeting, fiduciary risks and monitoring and evaluation. It also gives guidelines for behavior of stakeholders.

SWAp Committees and Sub-committees

144. The *SWAp Committee* is the agreed overall body for dialogue among all stakeholders in health: MoHSW, PMO-RALG, MoF, NGOs, private sector and DPs. There are two meetings a year - one is the Joint Annual Health Sector Review (JAHSR) and the other is a six-month interim progress meeting. Topics discussed are the health sector performance (including achievement of annual milestones, health sector indicators, progress of HSSP and public expenditure review); health sector plans and budget (MTEF); and other jointly agreed topics.

145. The *Technical Committee of the SWAp (TC-SWAp)* comprises representatives of the stakeholders in the SWAp. Membership among some stakeholders (NGOs and Development Partners) rotates representation among the numerous entities. It serves as a joint monitoring body of the goals and activities of the health sector as outlined in the Health Sector Strategic Plan II and III, Medium Term Expenditure Framework, Regional Health Plans and Comprehensive Council Health Plans. The Technical Committee has an advisory role; it deliberates on technical issues; makes proposals or recommendations to senior management in the MoHSW and PMO-RALG and to the SWAP Committee meetings on what actions need to be taken to address issues of health service delivery; advises the sector on how to carry out implementation; and gets

information from Ministry departments that need technical review before being submitted to the SWAp Committee.

Other committees

146. There are several sub-committees of the Technical Committee which ideally comprise a range of stakeholders, including the Monitoring and Evaluation Technical Working Group, the Health Financing Committee, the Maternal, Newborn & Child Health Partnership, the NATNETS Steering Committee, the HIV/AIDS Committee, the Human resources for Health Task Force. These subcommittees provide fora for discussion of specific topics, of interest to stakeholders in the SWAp. Development Partner membership in the relevant task force, working group or committee is expected for (i) all partners providing targeted project financing and/or technical inputs; (ii) technical experts within agencies. These subcommittees are intended to coordinate technical and policy advice, as well as financial and technical inputs.

Establishment and management of the Health Basket Fund

147. In June 1998, the Ministry of Health (now Ministry of Health and Social Welfare, MoHSW) and Development Partners (DPs) agreed to pursue a sector-wide approach (SWAp) to health sector reform. The SWAp aims at increasing coordination among donors and government, supporting one health sector program. More ambitiously, it aims to make systemic improvements, with increasing government ownership. The basket consists of two elements:

- The **central basket**, funding the Ministry of Health head quarters and other central organizations with central support functions.
- The **district basket**, funding running costs for District and Municipal Council health services based on annual action plans. The district basket aims at providing a stable and predictable resource base for local councils, complementing the District Health Block Grant from the Government of the United Republic of Tanzania. It also provides funds for PMO-RALG and RHMTs to oversee implementation of the district basket funds.

148. The Basket Financing Committee (BFC), comprising representatives of the MoHSW, PMO-RALG, MoF and basket-donors, is responsible for overseeing operation of the joint funding mechanism. Tasks of the BFC are to (a) approve the release of resources against the HSSP, MTEF, regional plans and CCHPs; and (b) ensure that the use of basket resources follow set financial, administrative and management procedures.

149. In 2000 procedures were agreed in the BFC for the disbursement of funds to MoHSW and LGAs. Allocation criteria for districts were formulated, taking into account population, remoteness, poverty and disease burden. Planning guidelines and conditions were formulated for use of the health basket grant by the Councils. Initially conditions restricted use of basket funds to running costs ("other costs"), excluding human resources costs and capital investments. Conditions were also formulated with regard to maximum levels for expenditure on allowances, fuel, etc. HBF funds were managed by GoT systems, accounted for as part of MoHSW's voted expenditure and processed using the GoT's Integrated Financial Management System. The HBF

accounting manual followed GoT financial management procedures. However, separate accounting took place, allowing for special auditing of funds from the basket.

The Memorandum of Understanding

150. The partners in the HBF employ a Memorandum of Understanding (MoU) which outlines in detail the roles, responsibilities and obligations of all stakeholders. The second MoU covered July 2003 until June 2008. A new MoU for the period 2008-2015 was signed end of July 2008. The MoU describes the implementation arrangements, including disbursement, procurement, audits, and reporting. The 2008 MoU signifies a step further in terms of alignment as all triggers for the disbursements are products regularly produced by the GoT and the audit will be no longer be produced separately for the basket fund but included in the Controller and Auditor General audit of the health sector (MoHSW, PMORALG, Council). The audit sub-committee (ASC) meets quarterly (or more often if needed), and is responsible for the analysis and monitoring of the CAG audits and follow-up actions. It is chaired by the Government. A special audit can be conducted on request of the DPs if a particular risk has been identified. In addition to the MoU, the BFC employs an annual "Side Agreement", which reflects financial commitments of DPs, agreements for the new fiscal year and any agreed amendments to the MOU. The MOU can also be amended through decisions in agreed minutes from the annual or any ad hoc HBF meetings. For FY12, the expected contributions to the health basket are as shown in Table A7.3.

Table A7.3 – Health Basket Fund Commitments and Tentative Amounts by DP (FY12)

Funding Organisation	Pledges 2011/12			
	Donor Currency (millions)		Current FX rate *	Estimate in US $ *
CIDA	25.0	CAD	*1.02*	25.60
Denmark	95.0	DKK	*0.19*	18.05
Ireland	6.5	Euro	*1.42*	9.22
Netherlands	15.0	Euro	*1.42*	21.29
Norway **	30.0	NOK	*0.18*	5.40
SDC	3.0	CHF	*1.11*	2.72
Germany (KfW)	7.0	Euro	*1.42*	9.93
World Bank **	22.0	USD	*1.00*	22.00
UNFPA	0.6	USD	*1.00*	0.60
UNICEF	1.0	USD	*1.00*	1.00
Total Estimated Pledge Based on estimated exchange rates				**115.81***

Notes:
* The amount in USD depends on the actual exchange rate at the date of disbursement. These estimates are based on exchange rate from http://www.xe.com/ web site accessed on March 21, 2011.
** Subject to approval by respective headquarters/Boards

151. The Audit Sub-Committee is currently functioning very well under the MOU, and is very pro-active in obtaining and reviewing audit reports and in discussing and monitoring the progress on the Plan of Action (POA) for dealing with the issues raised in each audit. In addition to the specific issues raised, the ASC also reviews the more systemic issues which may be giving rise to the examples cited in the audits. For example, the ASC is currently developing Terms of Reference to conduct a special audit of the Medical Stores Department, to provide assurance that the increased Basket Funds going to MSD is actually resulting in more medical supplies and medicines being available at the health facility level. Regular financial statements are also submitted to the ASC covering the Basket Funds. All of these items are reviewed by the ASC prior to submission to the following BFC. To date there have been very rare instances of ineligible expenditure under the Basket Fund. The only case in the last three years revolved around a number of minor works procurements in 2007/08 where the applicable procurement processes were not followed. The total amount involved was approximately $680,000 and this amount was refunded to the Basket Holding Account.

Resource allocation formula for Health Block Grants and Health Basket Funds

152. The annual allocation of funds from Central Government to the LGAs is currently based on a resource allocation formula that is used to distribute the Health Basket Funds and Health Block Grant. It takes into account the following factors:

- Population (70 %)
- Poverty count (10 %)
- District medical vehicle route (10%)
- Under-five mortality (10%)

153. In recognition of the individual as the main client-recipient of health and social welfare services, 70 percent of the Health Block Grant and the Health Basket are distributed in proportion to the population of each district. In addition to the overall population, districts receive additional resources for the special needs of a poor population (10% of the grant resources). The formula also recognizes the higher funding needs in rural areas by allocating 10% for the route mileage regularly travelled by health sector vehicles, taking into account the higher operational cost of delivering health services to a rural population and to sparsely populated areas; including higher costs faced in medicine distribution, immunization and supervision. Finally, the formula tries to direct resources (10%) to places with a high burden of disease; here the under-five mortality (U5M) is considered as an appropriate proxy for burden of disease.

Comprehensive Council Health Plans (CCHPs)

154. The Government of the United Republic of Tanzania through the MoHSW and PMO-RALG is empowering the Local Government Authorities (LGAs) through decentralization by devolving powers of decision making to the LGAs. Support will be given to them in prioritizing and planning their health and social welfare interventions based on priority needs. The LGAs will mobilize, manage and account for health and social welfare resources and implement health and social welfare activities in line with the National Health and Social Welfare Policies. The goal of improving health and social welfare services through decentralization of decision-making

and resources mirrors the vision of the Government for autonomous, empowered and accountable LGAs.

155. The CCHP is the principal prerequisite for any well functioning district health system. It includes objectives; strategies, interventions, activities to address health priorities and indicators to measure progress/performance (based on HMIS indicators). The CCHP is an annual health and social welfare plan for a Council to strengthen local health service planning, budgeting, implementation and reporting, the health plan collates the health and social welfare plans at all levels and involve all stakeholders. It addresses

i) the Policy and guidelines objectives related to:
   - Millennium Development Goals (MDGs);
   - Government Vision 2025;
   - National Strategy for Growth and Reduction of Poverty (NSGRP);
   - National Health Policy (2007);
   - Primary Health Services Development Program (2007-2017);
   - Health Sector Strategic Plan III (2009-2015);
   - The National Package of Essential Health Interventions (NPEHI) (2000);
   - National HRH Strategic Plan (2008-2013);
   - Council Health Strategic Plans;
   - Specific Programs Strategic Plans and Projects;
   - The Law of the Child Act (2009);

ii) the Burden of diseases nationally and locally and

iii) all sources of health funds including donations and funds in kind.

156. Funds for the implementation of the annual CCHPs have to be integrated into the Council's budget, therefore, the CCHP contains both recurrent and development activities within the sector that have to be matched with the identified source of funding for each activity including donations and funds/receipts in kind. The different sources of funds for implementing the CCHP are Health Block Grants (Other charges and Development), Health Basket Funds, Cost Sharing funds (NHIF, CHF/TIKA, User fee, Drug Revolving fund), Global Funds, Council own source, Receipt in kind, community contribution and other funding sources.

157. LGAs therefore need to prepare the Comprehensive Council Health Plans (CCHPs) under the guidance of the CCHP Guidelines and the Planning and Reporting (PlanRep) software. The Guidelines and software will ensure linkage of the CCHP targets to the relevant strategies and plans. In this context the third Health Sector Strategic Plan (HSSP III) July 2009 – June 2015 focuses on provision of equitable quality health and social welfare services and client satisfaction has been translated into CCHP planning and Reporting guideline at the implementation level. In order to promote coordinated planning and implementation of services within the health sector, the MoHSW has adopted a Sector Wide Approach (SWAp) strategy, which is concerned with the provision of accessible quality health and social welfare services in the LGAs, which are well supported, cost effective and gender sensitive with priorities developed according to the National Package of Essential Health and Social Welfare Interventions (NPEHSWI) of Tanzania.

158. A comprehensive plan has 3 aspects, namely Technical, Financial and Structural. In terms of the technical aspect, the CCHP should act on the main health and social welfare, problems and needs of the Council including promotive, preventive, curative and rehabilitative aspects. These main problems will be identified and analyzed in detail as part of the situational analysis, the review of resource availability and the priority problems. All CCHPs activities should be captured in the Planrep software in order to be able to monitor according to the indicators set. The financial aspect of the CCHP should take into account the following types of resources:

i. Block grant,
ii. Health Basket Fund,
iii. Council own sources,
iv. Cost sharing arrangements including prepayment schemes (fee for service, Community Health Funds, National Health Insurance, out of pocket)
v. Projects funds, programs and development partners.
vi. Receipts in kind

159. Utilization of Health Block Grants and Health Basket Funds is accompanied with a number of regulations and ceilings that must be respected. These regulations and ceilings are clearly elaborated the Guidelines. All CCHPs activities should be captured in the accounting system (IFMS/Epicor) in order to be able to monitor actual expenditure against what was budgeted. In terms of the structural aspect, Council health and social welfare services will operate at the household and community level, through dispensaries and Health centers, and in district and other hospitals. The services of all health and social welfare providers must be considered when preparing the CCHPs, including:

i. Public /Government providers
ii. Voluntary agencies/ FBOs
iii. Private for profit providers
iv. Parastatal providers
v. Non Governmental Organizations (NGOs)
vi. Community based initiative activities for health promotion
vii. Alternative medicine

Revised CCHP Planning and Reporting guideline

160. Since the Government of the United Republic of Tanzania through Decentralization and Sector-Wide Approaches started this arrangement there has been many important milestones achieved in its endeavours to improve health services for her people. One of the important milestones achieved is the arrangement of the disbursement of the Health Block Grant and Health Basket Fund to the Local Government Authorities (LGAs). Since 1999, a number of guidelines were developed to guide Councils or LGAs in preparing Comprehensive Council Health Plans for improving delivery of health services and ensure cost effective utilization of the funds. In order to facilitate the CCHP, CHMT members initially received considerable training and a Procedures Manual was developed in 2000. The manual was first revised in 2004 and a

third version (aligned with PlanRep2 software and including Tanzania Essential Health Interventions Project (TEHIP) planning DHA- tools) was published in 2007.

161. From early 2010 the fourth revised CCHP guideline has been developed to accommodate issues from the Health Sector Strategic Plan III (July 2009-June 2015), other agreed sector strategies and experiences gained by LGAs /Councils in using the previous guidelines and the arising need of incorporating the Social welfare services into the guideline. This new guideline will also serve as a tool to ensure that, the change process is well moderated by the Council Health Management teams and other stakeholders, in achieving the goal of improving Health service delivery through decentralization.

162. All partners in the health sector including the Local Government Authorities, Faith based organizations, Private sectors, Health institutions, Civil Societies, Local and International organizations both bilateral and multilateral will make use of this guideline effectively in improving performance both in planning, monitoring and evaluation of health service delivery. It requires the support of everybody to effect the changes that are desired.

Process of Developing the Comprehensive Council Health plans and progress reports

163. At the beginning of the calendar year, the Council Health Management Teams (CHMTs) are informed about the MoHSW priorities based in the National Package of Essential Health Interventions for the coming Financial Year and a ceiling for the District budget. Dispensaries and Health Centres develop their plans using the planning templates under the support of the CHMTs. Then Council Health Planning teams collate these plans and identify the most important health problems from these plans and incorporate them in their CCHP. The Planning Team then analyses the health problems within the health facility plan, then ranks them in order of priority for inclusion in the CCHP. Draft CCHPs are forwarded to the Regional Health Management Teams (RHMTs) for their scrutiny for quality assurance and consultations with CHMTs. The RHMTs consolidates CCHPs and progress report into the regional level and forward the consolidated CCHP report to MoHSW and PMORALG. Provide technical assistance to quality assure the CCHPs and Council reports and to compile summary reports for presentation to PMO-RALG and MoHSW.

164. The process of involving the RHMTs fully in seriously assessing the Council Health plans and progress reports was initiated only recently after the capacity of RHMTs was improved through specific capacity building which was done in May 2009.

Monitoring of CCHP implementation

165. CHMTs are responsible for the implementation of CCHPs, but are often restricted by various external and internal factors, e.g. delayed release of funds, and shortage of skilled human resource with inadequate capacity.

166. Also the information systems have room for improvement in terms of providing easy access to data relevant for monitoring progress in implementation of plans. So far the PlanRep software is not yet fully functional as CCHP monitoring instrument and limited compatibility

between PlanRep and the IFMS software in use "Epicor", is further restraining the automation of data that can be generated routinely by the monitoring system.

Quarterly and annual CCHP Implementation Reporting

167. All CCHP quarterly reports are assessed and scored by the RHMTs and forwarded to the central level. A team of staff from MoHSW/PMO-RALG then compiles a summary report for the Ministries and for BFC/SWAp partners. However, because many RHMT members are presently new and not fully conversant / experienced, the central MoHSW/PMO-RALG team also has to assess and own these for quality assurance and provide technical supportive supervision at these levels.

Disbursement of Funds from the Health Basket to LGAs

168. The disbursement mechanism for both the Health Block Grant and Health Basket Funds from the Centre to Councils will follow government procedures. However, condition for disbursement of Health Basket Fund is different from Block Grants. This section outlines in details the actual disbursement of Health Basket Funds to LGAs:

i. PMO-RALG in collaboration with MoHSW recommends LGA funding levels to the BFC , based on CCHPs and/or progress reports;
ii. Through the "Side Agreement", the BFC approves the transfer of funds from the Holding Account to Councils through Treasury, based on this recommended list;
iii. PMO-RALG prepares a request to the Accountant General to transfer the approved amount of funds from the Health Basket Fund holding account into the Exchequer Account. MoF will notify PMO-RALG and the BFC on the released of funds to Councils in writing;
iv. The Accountant General facilitates the transfer of funds from Exchequer Account to the respective Council's Development account. The Council Treasurer must inform the Council Medical Officer immediately in writing on receipts of funds after being credited in Development Bank Account. Auditors have to verify compliance to this requirement;
v. PMO- RALG notifies Councils with a copy to MoHSW, RS and Basket Partners of the amount of Health Basket Funds transferred, for follow up and comparison from the approved budgets;
vi. The disbursement of 1st quarter (July-September) funds depends upon submission of satisfactory January- March technical and financial progress reports and approved Comprehensive Council Health Plan for the current year.
vii. The disbursement of 2nd quarter (October – December) funds is subject to correct and timely submission of the Annual Council's technical and financial reports of the previous year (July – June).
viii. the disbursement of the 3rd quarter (January- March) funds to the Council subject to correct and timely submission of the first quarter (July –September) technical and financial report that also reports on progress made to attain expected outputs for that quarter.
ix. The disbursement of 4th quarter (April – June) funds will depend on October – December technical and financial reports.

Annex 8: Economic and Financial Analysis

157. Health expenditures include central government budgets through Ministry of Health and Social Welfare, local government budgets through (PMO-RALG), off budget payments from development partners, cost sharing revenue, revenue from public and private insurance, and household out-of-pocket expenditures.

158. Although a new National Health Accounts (NHA) is currently under development, the latest comprehensive figures are from 2005/06. Table A8.1 shows that there have been significant changes in both the size and composition of health expenditures between 2002/03 and 2005/06, with Total Health Expenditure (THE) more than doubling over the 3 years in question. The greatest increase (both in absolute and percentage terms), was seen in donor funds, and significant increases were also seen in public funding. While the proportion of private expenditure on health decreased considerably, from 47.1 percent to 27.8 percent, actual private spending still increased by TZS 88 billion, or 38 percent, with most of this increase coming from household out-of-pocket payments.

Table A8.1: Total Health Spending by Source of Funds

	Million TZS		Percent of Total		Total	Percent
	2002/03	2005/06	2002/03	2005/06	Increase	Increase
National expenditure on health	496,030	1,159,217	100.0%	100.0%	663,187	134%
Distribution by financing source (%):						
Public	126,140	325,740	25.4%	28.1%	199,600	158%
Donors	136,061	511,215	27.4%	44.1%	375,154	276%
Private	233,829	322,262	47.1%	27.8%	88,434	38%
o/w Household Out-of-Pocket	201,388	267,779	40.6%	23.1%	66,391	33%
Household Other	6,944	17,388	1.4%	1.5%	10,444	150%
Private Non-Household	25,496	37,095	5.1%	3.2%	11,599	45%

Source: Tanzania National Health Accounts (2008)

159. Both donor and public financing have continued to increase since 2005/06, so the results of the current NHA round will be quite important, especially in determining whether private funding has increased again as a share of THE or has continued its downward trend. These figures will have a significant impact on the assessment of potential future policy options for health financing.

Public Financing

160. This section examines public financing, which includes government spending and on-budget spending by development partners. Table A8.2 shows funding from public sources by year, including per capita spending and the percent of government spending. As can be seen, total public health sector spending increase almost four-fold between 2004/05 and the 2010/11 estimates. The largest increase has been in foreign non-basket funding, although a substantial part of this increase is the result of Global Fund grants (included in "non-basket" financing) moving from off-budget to on-budget.

161. A considerable amount of off-budget foreign funding (most notably funding from the U.S. Government) is not shown in the table. With the emergence of the United States Government President's Emergency Program for AIDS Relief (PEPFAR) and President's Malaria Initiative (PMI), significant off-budget resources have started flowing into the health sector. For example, PEPFAR funding in 2006/07 amounted to $205.5 million, increasing to $356.2 million by 2008/09. The latter figure represented 72 percent of total HIV/AIDS funding in FY09, and was greater than the actual expenditures by the MoHSW for that year[12]. PMI accounted for another $35 million in FY09, increasing to $52 million in FY10.

Table A8.2: Public Health Spending by Financing Sources (TZS million)

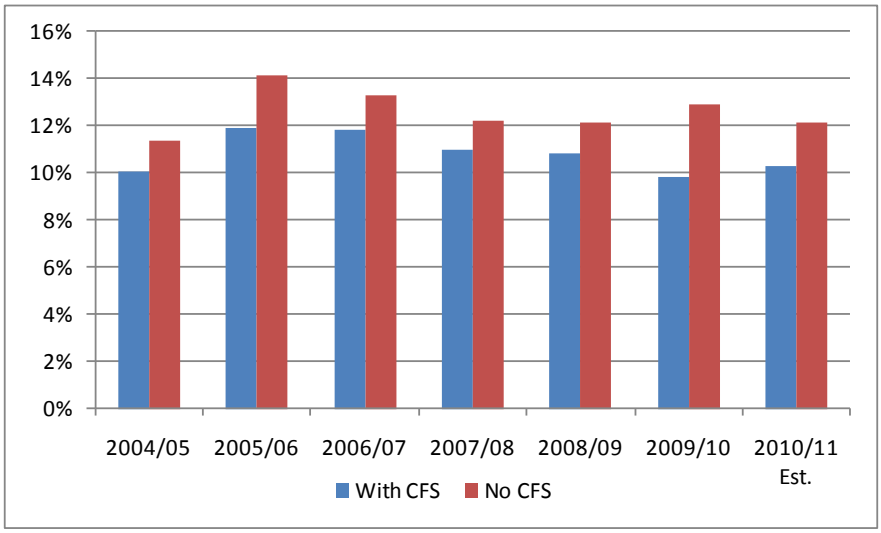
Source of Funds (TZS million)	2004/05 Actual Expenditure	2005/06 Actual Expenditure	2006/07 Actual Expenditure	2007/08 Actual Expenditure	2008/09 Approved Estimates	2008/09 Actual Expenditure	2009/10 Approved Estimates	2009/10 Actual Expenditure	2010/11 Approved Estimates
Government Funds	206,554	296,819	348,890	378,113	459,496	461,504	548,658	578,682	643,011
Foreign									
Basket	91,777	68,299	103,204	80,956	99,730	85,401	121,640	128,796	161,804
Non Basket	2,896	61,257	61,512	112,003	204,368	154,168	254,801	200,049	387,908
Total Foreign	94,673	129,555	164,716	192,959	304,098	239,569	376,441	328,845	549,712
Off-budget	3,384	3,363	2,964	15,289	0	5,858	0	10,784	0
Total	**304,612**	**429,738**	**516,570**	**586,361**	**763,594**	**706,931**	**925,099**	**918,311**	**1,192,723**
Real Spending (FY05=100)	**304,612**	**403,693**	**460,825**	**478,347**	**566,980**	**524,907**	**640,851**	**636,148**	**791,153**
Real per Capita (TZS)	**8,328**	**10,707**	**11,856**	**11,939**	**13,728**	**12,709**	**15,052**	**14,941**	**18,074**
Real per Capita (USD)	**7.51**	**8.98**	**9.49**	**9.46**	**10.40**	**9.63**	**11.34**	**11.26**	**12.31**
Total as % GoT (ex. CFS)	**11.3%**	**14.1%**	**13.3%**	**12.2%**	**11.1%**	**12.1%**	**11.6%**	**12.9%**	**12.1%**
Total as % GoT (inc. CFS)	**10.1%**	**11.9%**	**11.8%**	**11.0%**	**10.0%**	**10.8%**	**9.7%**	**9.8%**	**10.3%**
Percent of total									
Government Funds	67.8%	69.1%	67.5%	64.5%	60.2%	65.3%	59.3%	63.0%	53.9%
Basket	30.1%	15.9%	20.0%	13.8%	13.1%	12.1%	13.1%	14.0%	13.6%
Non Basket	1.0%	14.3%	11.9%	19.1%	26.8%	21.8%	27.5%	21.8%	32.5%
Total Foreign	31.1%	30.1%	31.9%	32.9%	39.8%	33.9%	40.7%	35.8%	46.1%

162. Government financing is decreasing as a proportion of total funding – from 69.1 percent in 2005/06 to an anticipated 53.9 percent in 2010/11. However, the large absolute increases in both government and external financing suggest that there may be limited room for further significant increases in government financing for health. On the other hand, at the recent UN MDG summit the President of Tanzania re-affirmed his government's commitment to achieving the Abuja Target of 15 percent of total government spending going to health.

163. Figure A8.1 highlights the recent experience in relation to this Target. While it shows some improvement in the 2009/10, the 2010/11 estimates revert back to the general trend has been downward for some time. This has been a result of the combination of robust general government revenue growth and several other high priorities within the government, including agriculture, education and infrastructure. The improvement in FY11 is largely the result of increases in Global Fund (GF) Grants (which are currently on-budget), which more than doubled from TZS 152.7 billion (equivalent to 31.9 percent of the total MoHSW budget) in 2009/10 to TZS 333.7 billion in 2010/11 (or 49.3 percent of the budget). Excluding the GF, the overall development budget increased by just 6.3 percent from TZS 107.9 to 114.7 billion, while the total budget increased by just 5.0 percent from TZS 326.3 to 342.5 billion. The recurrent budget increased by just 4.3 percent, which is barely above population growth.

[12] HIV/AIDS Public Expenditure Review, July, 2010.

Figure A8.1: Public Health Spending as a Percent of Total Government Expenditure



Source: Public Expenditure Review, 2008, 2009 and 2010.

164. These figures emphasize that the amount of GoT's own revenue available for the health sector has been limited. It is not likely that this will change in the foreseeable future, especially if external financing continues to be available and the other demands on Government revenue continue to increase. The combination of shrinking pledges to global health initiatives and the rapid utilization of the funds from existing Global Fund grants could result in an absolute decrease in the health sector budget in FY12, raising questions about the extent to which the Government will step in to keep the overall level of health financing stable. However, the scope for increased financing is limited by the other pressures mentioned above, as well as the current fiscal situation, which expects an overall budget deficit of 6.1 percent of GDP (12.1 percent before external financing) in 2009/10, up from 4.5 percent (9.4 percent) the previous year. This suggests that the fiscal space in terms of budget resources is very limited.

165. Global Fund grants, as well as most external financing other than the Health Basket funds, are earmarked to specific purposes, which results in extremely limited discretionary funding for the health sector. This means that significant increases in these funds are not translated into general increases in health service delivery. Either the Basket Funds or the allocation from the GoT's own resources would need to increase to have such an impact

166. The funding provided through this project would continue to support the health basket funds, which has been shown to have a positive impact on health outcomes. As noted in Table 1, Tanzania is on track to achieve the MDGs in Infant and Under-5 mortality, and it is expected that the HBF will continue to play a role in the achievement of these targets. For Infant Mortality, this means decreasing further from a rate of 51 per 1,000 live births to 38 per 1,000 by 2015, while for under-5 mortality, this means a decrease from 81 per 1,000 live births to 64 per 1,000. However, since the under-5 mortality rate includes infants, they have to be subtracted to determine the impact on under-5 non-infants. This calculation shows a required change from 30 per 1,000 live births to 26 per 1,000.

167. Table A8.3 shows that the achievement of these MDG would result in about 8,600 fewer infant and child deaths in 2011, increasing to 43,200 fewer deaths per year by 2015, the year in which the MDG targets would be reached. Using the average value added per year of $864.46 calculated from the Integrated Labor Force Survey of 2006 (updated to current GNI per capita), this translates into a discounted lifetime contribution to the economy of $21 million in 2011, increasing to $105 million in 2015 and each year thereafter. These contributions are discounted over the working life of those whose lives have been saved using the Internal Rate of Return (IRR). The IRR was set to equate the value of benefits to the costs incurred.

Table A8.3 – Cost-Benefit Calculation

Annual Births	1,600,000
Value added/year	$864.46
Participation rate	89.60%
Benefit Attributable to IDA	3.67%
IRR	8.70%

Year	Infant Lives Saved	NPV Value Added	IMR
2011	4,160	10.1	48.4
2012	8,320	20.2	45.8
2013	12,480	30.3	43.2
2014	16,640	40.5	40.6
2015	20,800	50.6	38.0
2016-2035	416,000	1,011.3	38.0
Total	478,400	1,163.0	

	U5 Lives Saved	NPV Value Added	U5MR	Total NPV
2011	4,480	10.9	29.2	8,640
2012	8,960	21.8	28.4	17,280
2013	13,440	32.7	27.6	25,920
2014	17,920	43.6	26.8	34,560
2015	22,400	54.5	26.0	43,200
2016-2035	448,000	1,089.1	26.0	864,000
Total	515,200	1,252.5		993,600

	Total Lives Saved	Total NPV Value Added	Attributable to IDA	NPV IDA Funding
2011	8,640	21.0	0.8	(25.0)
2012	17,280	42.0	1.5	(23.0)
2013	25,920	63.0	2.3	(21.2)
2014	34,560	84.0	3.1	(19.5)
2015	43,200	105.0	3.9	
2016-2035	864,000	2,100.4	77.1	
Total	993,600	2,415.5	88.6	(88.6)

168. As shown in the table on project costs and financing, the IDA funding is expected to account for 3.67 percent of the costs of the publicly financed health sector between 2011/12 and 2014/15, thus that proportion of the benefits have been assigned to this investment.

169. Overall, this analysis shows that the IRR for this project would be 8.70 percent, based solely on the achievement of MDG 4. Clearly the impact of the project would be substantially greater than only MDG 4, but on the other hand there will be factors outside of the health system which will also have an impact on MDG 4. This rate of return can be seen as a fairly conservative estimate of the impact of the project using data that is readily available.

Annex 9: Projects with Basket Funds which Support Local Government Authorities

Project	**Agricultural Sector Development Project (ASDP)**	**Local Government Support Project (LGSP)**	**Water Sector Support Project**	**Health Sector Development Program – Phase 2 (HSDP II)**
Closing Date	06/30/2013	06/30/2012	02/29/2012	06/30/2011
Amount (incl. AF)	$156.85 million	$155.68 million	$210.58 million	$165.00 million
Disbursed	$84.01 million	$123.77 million	$99.82 million	$161.69 million
Number of AF	2	1	0	2
Components providing support to Local Government Authorities (LGA's)	**Local Level Support** to improve LGA capacity to plan, support and co-ordinate agricultural services and improve the local regulatory environment for economic activity in agriculture, particularly local level taxation. Sub-components include: (i) agricultural investment, (ii) agricultural services, and (iii) capacity building and reform.	**Local Government Capital Development Grant System** supports (a) Council Development Grant (CDG), and (b) Capacity Building Grant (CBG). LGDG transfers will be non-sectoral, distributed on a formula basis to LGAs, who will invest in accordance with local needs. CBG provides resources to help build capacity to access/manage the CDG	**Scaling-up of Rural WSS**: support LGAs in providing water and sanitation services by implementing District WSS Plans. Includes improvements in water supply (e.g., shallow wells, boreholes with hand pumps) and sanitation services (latrine promotion and hand washing) to rural communities, health centers, and schools.	**Pooled Financing:** supports implementation of annual work programs to facilitate achievement of the Health Sector Strategic Plan. Focuses on District Level Health Services, Central Level Health Services, and supportive supervision through RHMT's and PMO-RALG.
	National Level Support to reform agricultural services, primarily research and extension; improve the sector policy framework; carry out preparatory work and investment in national level irrigation; simulate market development; and improve food security/ sector co-ordination. Sub-components: (i) agricultural services; (ii) irrigation development (proposed Basket Fund; (iii) market and private sector development; (iv) food security; and (v) co-ordination, M&E.	**Management and Institutional Development** supports PMO-RALG in the implementation, monitoring, evaluation and audits of the Project and the transfer program supported by Component 1 while building the capacity of PMO-RALG to execute the functions as part of routine activities.	**Scaling-up of Urban WSS Services** supports the execution of utility business plans and support improvements in water supply (mainly piped schemes) and sanitation services (sewerage systems, latrines promotion, hand washing program). In particular, services to the urban poor will be emphasized.	**Non-Pooled Financing:** supports specific investments that are difficult to finance through pooled funding arrangements, including support for the Under 5 Bed Net campaign, the purchase of Emergency Obstetrical Equipment and support for Food Fortification.
Partners	WB, EU, Japan, Irish Aid, IFAD, and DANIDA have in principle agreed to provide joint support to the program through the ASDP Basket Fund	WB, Netherlands, Ireland, Denmark, Finland, Norway, Sweden, DFID, EU and UNDP/UNCDF	WB, AfDB, USG, Germany, JICA, France, Netherlands, Switzerland, UN Habitat, GEF	WB, Germany, Ireland, Denmark, Norway, Switzerland, UNICEF, UNFPA, UN System, Canada, Netherlands
Basket Fund	Yes	Yes	Yes	Yes
LGDG linkage	Yes	Yes	Yes (RWSS only)	No

Project	**Agricultural Sector Development Project (ASDP)**	**Local Government Support Project (LGSP)**	**Water Sector Support Project**	**Health Sector Development Program – Phase 2 (HSDP II)**
Steering Committees (SC)	(i) ASDP Basket Fund Steering Committee (ii) LGDG Steering Committee	(i) LGDG Technical Committee (ii) interministerial SC at PS-level	(i) Water Sector WG (ii) LGDG Technical Committee (iii) interministerial SC	Health Basket Financing Committee
Coordination Body	ASDP Secretariat: coordinator, M&E officer, info. officer	Program Support Team (PST): coordinator/ manager, FM specialist procurement specialist, HR and inst. dev. specialist, support staff	Mainstreamed into MOW, with no specific staffing identified	Mainstreamed into MoHSW and PMO-RALG, with no specific staffing identified
Funds Flow	Based on the decision of the ASDP BFSC and LGDG Committee, funds will flow from an ASDP pooled holding account in the Bank of Tanzania, through the exchequer to LGAs and line ministries.	Quarterly releases from a Special Account to GoT consolidated account (CA). Releases from CA to LGA Dev. Fund Account 2, then to District Fund Accounts and District LGSP Accounts (one for CDG and one for CBG)	RWSS – through LGDG system UWSS – annual grants following submission of annual workplan and draft business plan.	Based on the decision of the ASDP BFSC and LGDG Committee, funds will flow from an ASDP pooled holding account in the Bank of Tanzania, through the exchequer to LGAs and line ministries.