Report Number : ICRR0020727

1. Project Data

Project ID	Project Name	
P125740	TZ-Basic Health Services Project (FY12)	
Country	**Practice Area(Lead)**	**Additional Financing**
Tanzania	Health, Nutrition & Population	P147991

L/C/TF Number(s)	Closing Date (Original)	Total Project Cost (USD)
IDA-50290	30-Jun-2015	2,721,800,000.00
Bank Approval Date	**Closing Date (Actual)**	
20-Dec-2011	30-Oct-2016	

	IBRD/IDA (USD)	Grants (USD)
Original Commitment	100,000,000.00	0.00
Revised Commitment	100,000,000.00	0.00
Actual	95,092,689.02	0.00

Prepared by	Reviewed by	ICR Review Coordinator	Group
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2. Project Objectives and Components

a. Objectives

According to the Financing Agreement, the Project Development Objective (PDO) of "the Project is assist the Recipient in improving the equity of geographic access and use of basic health services across districts and enhancing the quality of health services being delivered."
The PDO as stated in the Project Appraisal Document (PAD) was identical.

b. Were the project objectives/key associated outcome targets revised during implementation?

No

c. Will a split evaluation be undertaken?

No

d. Components

Component 1 – Support to Local Government Service Delivery. (Total cost at appraisal: US$ 1,323.8 million of which IDA: US$80 million; Actual IDA: US$85 million). The component disbursed to the Health Budget Fund (HBF), which is managed by Local Government Authorities (LGAs) to deliver health services through public dispensaries, health centers and district hospitals. Disbursement to the HBF were calculated using an average allocation to the LGA's of approximately US$0.30/capita per year.

Component 2 – Capacity Building in Local Governments (Total cost at appraisal: US$ 51 million of which IDA: US$11 million; Actual IDA: US$3.4 million). The component, through the Capacity Building Grant (CBG) mechanism of the Local Government Development Grant (LGDG), supports councils with Capacity Building Plans to improve the management of health services. The grant financed technical assistance, training and systems strengthening interventions, to help improve overall performance at the LGA and health facility levels. This includes, *inter alia,* improving Comprehensive Emergency Obstetric capability as well as capacity related to Health Management Information Systems (HMIS) and to M&E.

Component 3 – Central Programs to Support Local Service Delivery (Total cost at appraisal: US$ 1,346.9 million of which IDA: US$ 8.5 million; Actual IDA: US$ 6.6 million). The component provided funding through the HBF and non-pooled funding for central level activities: (i) overall project management and monitoring activities of the Regional Health Management Team (RHMTs), of the Prime Minister's Office–Regional Administration and Local Government (PMO-RALG); (ii) ensuring Comprehensive Council Health Plans (CCHPs) are adequately analyzed and monitored; and (iii) implementation of health care waste management.

e. Comments on Project Cost, Financing, Borrower Contribution, and Dates

Project Cost, Financing and Borrower Contribution: Total financing of the program at appraisal was US$ 2,721.80 million, comprising: (i) US$ 1,659.6 million of borrower financing; (ii) US$ 371.2 million of pooled donor financing; (iii) US$ 591 million of non-pooled donor financing; and (iv) US$ 100 million of IDA allocation. However, due to exchange rate fluctuation between Special Drawing Rights (SDR) and United States Dollar (US$), US$ 4.9 million of IDA were lost and only US$ 95.1 million of IDA were disbursed. Also, the amount of pooled funds provided by donors was reduced to a total of US$ 353.61 million.

Dates: Two Level-2 restructurings were processed, which provided additional time to the Ministry of Health and Social Welfare (MOHSW) to complete some of the planned health-care-waste-management

and procurement activities under the non-pooled portion: (i) On May 13, 2015, a 10-month no-cost extension of the project closing date from June 30, 2015 to April 30, 2016; and (ii) on April 22, 2016, a 6-month no-cost extension of the closing date from April 30, 2016 to October 30, 2016.

3. Relevance of Objectives & Design

a. Relevance of Objectives

Project's objectives of improving the equity of geographic access and use of basic health services and enhancing their quality are fully aligned with two of the four objectives set out in the CAS FY2012-15, which was extended to 2016: (i) strengthening human capital and safety nets, which aims to improve, inter alia, access to and quality of health service; and (ii) promoting accountability and governance, which is a crosscutting objective to improve accountability and efficiency of public management.
The project is also aligned with the overall mission of GOT's Health Sector Strategic Plan (HSSP) IV, which is to ensure "the provision of basic health and social welfare services that are of good quality, equitable, accessible, affordable, sustainable, and gender sensitive".

Rating
High

b. Relevance of Design

The project built on the SWAp arrangement of the previous Health Sector Development Projects (HSDPI and HSDPII) that provided lessons on donor harmonization and alignment with national priorities. However, some of the other features of the HSDPII were not continued, as the project: (i) used a stand-alone set of indicators, rather than indicators used by the Government of Tanzania (GOT); and (ii) did not use survey data for validation, possibly because efforts were being made to strengthen the HMIS.

Rating
Substantial

4. Achievement of Objectives (Efficacy)

Objective 1

Objective
Improving utilization of basic health services across districts

Rationale

Outputs

- Around 29.7 million of children received a dose of Vitamin A, surpassing the target of 29 million children.
- A total of 48.6 million patients benefited from the project (of which 51.4 percent female) surpassing the target of 37.1 million children (and 50.5 percent female).
- About 10.8 million pregnant women received antenatal care during a visit to a health provider, surpassing the target of 6.5 million.

Intermediate outcomes

- Over the course of the project, 8,016,240 children were immunized, exceeding the target of 6,142,347.
- The percentage of births attended in a health facility reached 62.4 percent at the end of the project, which represented an improvement from the baseline value of 58.4 percent, but remained below the target of 69 percent.
- The average number of outpatient attendances per clinical staff reached 2,259 at the end of the project, exceeding the target of 1,600.
- The average number of outpatient attendances per capita decreased from the baseline value of 0.83 to 0.65 at the end of the project. Thus, the target of 1.00 was not reached.

Rating

Substantial

Objective 2

Objective

Improving the equity of geographic access of basic health services across districts

Rationale

Outputs

- The use of performance and equity indicators in LGA allocations did not reach the expected levels. The Service Delivery Grant (SDG) was not established, and the equity-based allocation revised in 2012 was used only for the Health Basket Fund (HBF).
- The quality of audits performed by LGAs improved, and the percentage of LGAs with unqualified audit reports reached 86 percent, which exceeded the target of 48 percent.
- By the end of the projects all LGAs had implemented the new district monitoring and information system (DMIS) in all districts (the target was 70 percent).

Outcomes

- Percentage of deliveries at a health facility: in the three regions where access was particularly problematic (Mara, Mwanza, and Shinyanga), the percentage of deliveries at a health facility improved (from 32, 48, and 45 percent to 47, 53, and 57 percent, respectively) but did not reach the PDO target of 69 percent.
- The number of Outpatient Department (OPD) visits per person per year: over the project period, the number of OPD visits per person a per year declined, which implies a decline in utilization of services.
- The number of pregnant women who availed one Ante-Natal Care (ANC) visit: ANC coverage declined in the three regions over the project period.
- The reduction in ratio of the 10 best performing Local Government Authorities (LGAs) to the 10 worst performing LGAs was achieved only for 1 indicator.

Rating
Modest

Objective 3
Objective
Enhancing the quality of health services being delivered

Rationale
Outputs

- Around 48 percent of health centers provide emergency obstetrical care (EMOC) by the end of the project, compared with 5.5 percent at baseline. This surpassed the target of a 20 percent increase.
- At the end of the project, the District Readiness for Service Delivery score was 55.3 percent. However, the baseline was not defined at appraisal. Therefore, even if a target of 20 percent increase was set, it is not possible to determine whether the target was achieved.
- The use of performance and equity indicators in LGA allocations did not reach the expected levels. The SDG was not established and the equity based allocation revised in 2012 was used only for HBF.
- The quality of audits performed by LGAs improved, and the percentage of LGAs with unqualified audit reports reached 86 percent, which exceeded the target of 48 percent.
- By the end of the projects all LGAs had implemented the new district monitoring and information system (DMIS) in all districts (the target was 70 percent).

Outcomes

- The percentage of health facilities with any stock outs of tracer medicines and vaccines according to Comprehensive Council Health Plans (CCHPs) was 53 percent at the end of the project, which represents a deterioration in performance compared to the baseline value of 28 percent.

Rating
Modest

5. Efficiency

Reliance on existing structures avoided the creation of new set-ups and the associated costs. In addition, the use of a SWAp modality reduced the costs associated with coordination among development partners. The HBF (to which 90 percent of the project proceeds went) played an important role in health care financing and has generally been pro-poor in its allocation. However, allocative efficiency of the project (spending on the right things) is low/negligible given the limited progress made in achieving project outcomes. There was an apparent lack of flexibility in the use of HBF resources which prevented its effective use and somewhat limited autonomy of the LGAs.
There were delays in initiating the non-pooled portions as the designated accounts were not set-up in a timely manner. Low utilization of the non-pooled portion of the project funds was noted – 52 percent of allocation, primarily due to delays in procurement (National Audit Office, 2015) – but improvements were noted in 2016 when 99 percent of the funds were used. Moreover, the fact that the pooled and the non-pooled portions operated like two projects in parallel, limited implementation efficiency of the project.
The ICR estimated the economic benefits gained due to reductions in infant mortality rate (IMR) and maternal mortality rate (MMR) between 2010 and 2015: for US$1 invested by the project, benefits generated are in the range of US$0.23 and US$0.69 when IMR is considered; US$0.41–1.22 for U5MR; and US$0.19–0.58 for MMR. The project has generated economic benefit of US$23–69 million from reduction of IMR, and between US$19–57 million from reducing MMR. However, given the lack of data and the inability to undertake an impact evaluation, it is not possible to measure the real impact of the project.

Efficiency Rating
Modest

a. If available, enter the Economic Rate of Return (ERR) and/or Financial Rate of Return (FRR) at appraisal and the re-estimated value at evaluation:

	Rate Available?	Point value (%)	*Coverage/Scope (%)
Appraisal	✓	0	0 ☐Not Applicable
ICR Estimate	✓	0	0 ☐Not Applicable

* Refers to percent of total project cost for which ERR/FRR was calculated.

6. Outcome

Relevance of the objective is rated high and relevance of design is rated substantial. The achievement of the first objective to improve use of basic health service across district is rated substantial, the second and third objectives to enhance equity and quality of health services are rated Modest. Efficiency is rated modest.

a. Outcome Rating

Moderately Unsatisfactory

7. Rationale for Risk to Development Outcome Rating

Some of the risks that were there at appraisal are still relevant. These include the capacity constraints of the LGAs, and M&E data quality issues, although some progress has been made in these areas. Additionally, the following risks exist:

- Vertical programs account for a larger portion of the district budgets. The GOT will need to reduce its reliance on external financing as funds from development partners are expected to decline with Tanzania transitioning to a middle income country.
- Systemic inefficiencies at the Medical Stores Department resulting in medicine stock-outs.

a. Risk to Development Outcome Rating

Modest

8. Assessment of Bank Performance

a. Quality-at-Entry

The project was strategically relevant, being well-aligned with the GOT's priorities and the Bank's strategies. The pooled portion built on the previous Bank-financed health projects that had a similar SWAp arrangement. The concept of the project was logical, but the design was complex with over-ambitious targets and unclear implementation arrangements, particularly for the non-pooled portions. The choice of indicators for the results framework was not appropriate, as many of the indicators were not adequately defined (e.g. the indicators measuring achievement of the equity objective). The procurement capacity assessment was not done for the Medical Stores Department and LGAs even though these entities used project proceeds to procure medicines.

Quality-at-Entry Rating
Moderately Unsatisfactory

b. Quality of supervision
Continuing with the practice of the previous health projects, the Bank led the Basket Financing Committee for most of the project duration, which proved to be advantageous for donor coordination purposes as well as leading the dialogue with the GOT. Supervision missions were conducted every six months with reasonably staffed teams. Procurement of medicines by the Medical Stores Department (worth US$42 million allocated from the HBF) mostly used international tenders that were not prior or post reviewed by the Bank, although the PAD stated that the Bank would provide procurement oversight for such tenders. No reviews were undertaken to assess the compliance of LGAs with health-care waste-management guidelines. The Bank did not pay sufficient attention to progress (or lack thereof) toward achievement of intended outcomes of the project, or to trends in indicators. The results framework was not revised to address the design problems. Interim results that fed into the ISR reports were self-reported data extracted from the weak MoH and District-level MIS without quality audit and/or third-party verification. Although many of these problems were noted in the ISRs, the PDO and implementation progress were consistently rated moderately satisfactory, signaling good project performance when the underlying project performance was questionable. The Bank could have put in more effort in extracting reliable results to justify the investments. Turnover of Bank staff, with five Task Team Leaders over the five-year period, may have affected continuity of the project. Compliance with safeguards policies was not reported.

Quality of Supervision Rating
Unsatisfactory

Overall Bank Performance Rating
Unsatisfactory

9. Assessment of Borrower Performance

a. Government Performance
The fact that HSSP III was a government document suggests the GOT was fully committed to the SWAp to which this project contributed. The HSSP ensured harmonization of development partner funding to national priorities and continued commitment of the GOT. The share of GOT’s budget devoted to the health sector declined from 8.94 percent in FY2011/12 to 8 percent in FY2014/15, which suggests a reliance on development partner funding for the sector. The GOT funds were mostly used for paying salaries and, hence, the districts had to rely more on development partner financing for operational costs. Delays in fund release by MOF affected project implementation.

Government Performance Rating
Moderately Satisfactory

b. Implementing Agency Performance
The main implementing agencies were the MOHSW and PMO-RALG. The team at the MOHSW present during project design was replaced by an entirely new team during implementation with no transitioning and/or hand-over; the ICR does not provide details on the reasons. This sudden staffing change adversely affected the non-pooled portions in particular. Appointment of the Project Coordinator in the second year of the project greatly benefitted implementation. Synergies between the pooled and non-pooled portions were limited due to lack of clarity of the project concept and disagreements between the MOHSW and PMO-RALG. Weak technical expertise of PMO-RALG meant that supportive supervision provided to the LGAs was not sufficient. This was aggravated by the weak institutional capacity of the LGAs and improper distribution of skilled human resources for health (HRH). There were insufficient institutional and technical capacities to handle environmental and social issues. Due to a large number of ongoing interventions, the MOHSW could not provide adequate technical input to the districts and HBF suffered from lack of oversight.

Implementing Agency Performance Rating
Moderately Unsatisfactory

Overall Borrower Performance Rating
Moderately Unsatisfactory

10. M&E Design, Implementation, & Utilization

a. M&E Design
The PDO aimed to improve three aspects of service delivery – equity of geographic access, utilization, and quality. Although the PAD clearly identified the indicators that will measure each of these three aspects, there were problems with defining and monitoring of these. There were significant shortcomings in the architecture as well as monitoring of the results framework which set some unrealistic and aspirational targets and did not include SMART (specific, measurable, attainable, reliable, timely) indicators. Questionable M&E design decisions include: (i) monitor HBF using a set of {how many} indicators that was different from that used by the GOT to monitor HBF (except for one indicator which was common); (ii) the decision of not using the Demographic and Health Survey (DHS) 2010 as data source to monitor inequity in health outcomes.

b. M&E Implementation
The Bank used M&E arrangements under the SWAp to monitor progress in the implementation of the HBF (i.e. the pooled portion of the project). For the non-pooled portions, the Bank fielded six-monthly missions for monitoring progress and providing implementation support. A Bank team based in the country office provided

implementation support. Using project proceeds, 20 M&E officers were placed at the regional level to accelerate implementation of the new District Health Information System (DHIS version 2).

c. M&E Utilization

Many of the management tools were not used effectively and to their full potential, particularly PlanRep. Due to a lack of reliable data, the DHIS2 could not contribute effectively to decision-making processes. The project's results framework had weaknesses and these were not given sufficient attention during supervision. Consequently, there was limited use of data collected in the M&E of the project in decision-making.

M&E Quality Rating

Modest

11. Other Issues

a. Safeguards

The project triggered one of the Bank's Operational Policies, 4.01 "Environmental Assessment" due to the potential impact caused by medical waste. Component 3 supported the MOHSW for implementing health care waste management (HCWM) activities, mostly at the regional and national referral hospitals. A major achievement included revision of various HCWM guidelines and procedures including HCWM Regulations signed by the Minister of Health. During implementation, a cross-check was not done to assess if HCWM activities were included in the CCHPs and implemented at the district and below-level facilities. According to the ICR (p. 14), "In the absence of any review of HCWM activities at the field level, it is difficult to ascertain if HCWM activities were adequately practiced by the facilities." Other challenges relating to HCWM included: (i) initial delays in procuring HCWM equipment by the MOHSW; and (ii) lack of modern incinerators at the regional hospitals. The ICR does not state if the project complied with safeguard policies.

b. Fiduciary Compliance

Procurement arrangements for Health Basket Fund (HBF) portion of the project was done by the Medical Stores Department (MSD) as well as the LGAs, but their capacity was not assessed by the Bank. Although the PAD states that the Bank would have provides procurement oversight for the international tenders financed by the HBF; in reality, this was not practiced in tenders by MSD. For procurement done using the HBF, the Bank relied exclusively on the audits performed by the Controller and Auditor General (CAG) of GOT.

A special audit done by CAG on drug availability at MSD on request of the HBF partners in December 2011, revealed systemic weaknesses and inefficiencies at MSD (National Audit Office of Tanzania, 2011). Consequently, the share of HBF allocated to MSD was reduced from 17 percent in FY2012/13 to 14 percent

in FY2014/15 and more were funds allocated to the LGAs for procuring medicines. Some of the challenges at MSD included: i) no evidence of drugs delivered by MSD reaching the end users; ii) stock of expired drugs at MSD; iii) MSD accepted drugs that had less than 80 percent shelf life; and iv) possible leakages. Additionally, an audit trail was not properly maintained in MSD and anyone could delete information relating to procurement and inventory.

Procurement for non-pooled activities was performed by the MOHSW following Bank's procedure. Some initial delays in procurement were overcome during implementation through capacity building. Post-review audits done by the Bank did not reveal significant issues.

Financial reporting arrangement was changed to Interim Unaudited Financial Report (IFR) for the pooled portion and Statement of Expenditure (SOE) for the non-pooled portions due to insufficient capacity in the MOHSW and PMO-RALG. The Bank's financial management assessment at appraisal did not identify this issue, and it was expected that IFR could be prepared. During implementation, the risk mitigation measures instituted resulted in modest improvements in the financial management capacity as evident from: i) IFRs prepared accurately by the LGAs for HBF; ii) no significant financial irregularity found in CAG audits; iii) the Bank found internal control mechanisms and internal audit arrangements to be adequate. The software used for tracking expenditure, the EPICOR software, was not fully utilized in processing financial reports and manual records were maintained (MOHSW, 2013c). This manual processing caused delays in finalizing reports. Capacity building initiatives included professional qualification of accountants, training conducted by the World Bank, workshop for MOHSW accountants, training on accruals basis of training, etc.

c. Unintended impacts (Positive or Negative)

None reported.

d. Other

None reported.

12. Ratings

Ratings	ICR	IEG	Reason for Disagreements/Comment
Outcome	Moderately Unsatisfactory	Moderately Unsatisfactory	---
Risk to Development Outcome	Modest	Modest	---
Bank Performance	Unsatisfactory	Unsatisfactory	---
Borrower Performance	Moderately Unsatisfactory	Moderately Unsatisfactory	---

Quality of ICR	Substantial	---

Note
When insufficient information is provided by the Bank for IEG to arrive at a clear rating, IEG will downgrade the relevant ratings as warranted beginning July 1, 2006.
The "Reason for Disagreement/Comments" column could cross-reference other sections of the ICR Review, as appropriate.

13. Lessons

The ICR (p. 28-30) identified several valuable lessons, including the following:

1. When a SWAp comprises both on-budget and off-budget sources, it would be beneficial to have measures in place for consolidating the parallel sources under the SWAp umbrella, for greater harmonization, to ensure complementarity and to avoid competing demands on human resources.
2. The functioning of M&E should be a priority from the start of the project rather than towards the end. Bank teams should proactively revise the results framework if problems are identified (e.g. define SMART indicators for which regular updates are available). Wherever possible, the results framework should include indicators that are already being tracked by the government to avoid the need to rely on additional player(s) for reporting on the project's outcomes. However, if M&E systems rely on country systems, additional measures should be instituted that provide adequate quality assurance. In this case, the project could have factored in alternative mechanisms for validating/triangulating data, for example through regular surveys, instead of relying fully on the HMIS. Similarly, third-party verification administered jointly with the government would have been useful.
3. The institutional arrangements of a project should match the country capacity. During design, rigorous assessment and/or in-depth analytical work should be undertaken to institute implementable activities. The institutional and financial arrangements of the pooled and non-pooled portions of the project continued as two parallel interventions. Also, it would have been useful to have a detailed project operation manual so that subsequent teams could easily understand the project concept and implementation arrangements.
4. Frequent changes of Bank task team leaders (TTLs) can adversely affect implementation and outcomes. It is important to have well-organized handovers. The change in TTLs happens for a variety of reasons, but when there are relatively frequent changes, as was the case for this project, systematic TTL handover is needed, as well as management oversight of operational risks posed by frequent turnover.

14. Assessment Recommended?

No

15. Comments on Quality of ICR

The ICR is candid and provides an excellent overview of context around the preparation of the project and of the challenges during its implementation. The ICR utilizes survey data such as the DHS 2010 wherever possible. The assessment of challenges and missed opportunities during project implementation is balanced. However, the ICR does not indicate if the project complied with the Bank's safeguards policies.

a. Quality of ICR Rating
Substantial