TANZANIA—Health and Nutrition Project (Credit 2098–TZ)

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IMPLEMENTATION COMPLETION REPORT

TANZANIA

HEALTH AND NUTRITION PROJECT

[CREDIT NO. 20980]

DECEMBER 28, 1999

Africa Human Development Group 1
Eastern and Southern Africa
Africa Region

CURRENCY EQUIVALENTS

Currency Unit = Tanzania Shilling
Appraisal: US$1 = Tsh 193; Closing: US$1 = Tsh 680

Weights and Measures
Metric System
Fiscal Year of Borrower
Central Government: July 1 – June 30; Local Government: January 1 – December 31

ABBREVIATIONS AND ACRONYMS

AIDS – Acquired Immune Deficiency Syndrome
APL – Adaptable Program Lending
CHF – Community Health Fund(s)
CMS – Central Medical Stores
CSP – Cost Sharing Program
DANIDA – Danish International Development Agency
DCP- Drug Capitalization Program
DHB – District Health Board(s)
DHMT – District Health Management Team(s)
DMDT – Department of Manpower Development and Training
DMO – District Medical Officer
GOT – Government of Tanzania
HIV – Human Immuno-deficiency Virus
HMIS – Health Management Information System
H&N – Health and Nutrition
HRD – Human Resource Development
HSR – Health Sector Reform
ICR – Implementation Completion Report
IDA – International Development Association
MOH – Ministry of Health
MRALG – Ministry of Regional Administration and Local Government
MPH – Master's in Public Health
MSD – Medical Stores Department
NHI – National Health Insurance
PHC – Primary Health Care
PIU – Project Implementation Unit
PHN – Population, Health and Nutrition
PS – Permanent Secretary
PSN – Project Support Network
QAG – Quality Assurance Group
SAR – Staff Appraisal Report
SDC – Swiss Development Corporation
SDR – Special Drawing Rights
SWAp – Sector Wide Approach
TFNC – Tanzania Food and Nutrition Council
USAID – United States Agency for International Development

Managers and Staff Responsible
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TABLE OF CONTENTS

Appendices

Appendix A: Completion Mission's Aide Memoire
Appendix B: Proceedings of the MOH and MRALG Internal Assessment Workshop for the H&N Project
Appendix C: Borrower's Comments on the Draft ICR
Appendix D: Map of Tanzania

IMPLEMENTATION COMPLETION REPORT

TANZANIA

HEALTH AND NUTRITION PROJECT (TZ-PE-2774)

PREFACE

1. This is the Implementation Completion Report (ICR) for the Tanzania Health and Nutrition (H&N) Project, for which Credit No. 20980 (Sector Investment Loan) in the amount of SDR 36.1 million (US$47.6 million equivalent at the prevailing exchange rate) was approved on March 6, 1990, signed on March 7, 1990, and made effective on April 6, 1990. The credit closed on June 30, 1999; the original closing date of June 30, 1996 was extended for two years in 1996 and for another year in 1998. The last disbursement was made on November 3, 1999. An undisbursed balance of SDR 2.4 million (US$ 3.3 million at the prevailing exchange rate) will be cancelled once funds due from the Government are received and the accounts are closed. Any undisbursed balance will be cancelled.

2. The ICR was prepared by Mr. Oscar F. Picazo, Economist of the Human Development Group 1, Eastern and Southern Africa (AFTH1), with assistance from Mr. David Robalino, Young Professional, AFTH1. It was reviewed by Mr. Dzingai Mutumbuka, Sector Manager, AFTH1, and Mr. James W. Adams, Country Director for Tanzania. Additional comments were received from Dr. Philip Gowers, Principal Health Specialist, Ms. Chiyo Kanda, Task Team Leader of the project, and Mr. Andrew Follmer, Operations Analyst, all of AFTH1. The draft tables in the Annex were prepared by Dr. Faustin Njau, the Project Coordinator for Component I; Mr. Barney Laseko, Financial Management Specialist, AFMTZ; Ms. Emily Mwai, Information Technology Assistant, AFTH1; Mr. Robalino, and Mr. Picazo. The borrower reviewed the report before it was finalized.

3. The report was initiated during an ICR mission from September 17 to 21, 1999, comprising of Dr. Emmanuel Malangalila, Social Sector Advisor, AFMTZ; Mr. Picazo; and Mr. Laseko. The ICR is based on information collected during that mission, discussions with borrower representatives, and data from project files. The borrower assisted in the preparation of the ICR by contributing views as reflected in the Completion Mission's Aide Memoire (Appendix A) and by holding an internal assessment workshop jointly sponsored by the implementing agencies, the Ministry of Health (MOH) and the Ministry of Regional Administration and Local Government (MRALG) (Appendix B). This ICR reflects many of the inputs, comments, and observations made during this workshop. The Government also provided comments as it evolved and formally responded to the draft ICR (Appendix C).

IMPLEMENTATION COMPLETION REPORT

TANZANIA

HEALTH AND NUTRITION PROJECT (CR. TZ-PE-2774)

EVALUATION SUMMARY

Introduction

1. The Government of Tanzania (GOT) undertook the Health and Nutrition (H&N) Project to raise the quality, coverage and effectiveness of family planning, nutrition and basic health services in the country. The Project is the first IDA credit in the sector, amounting to SDR 36.1 million (or US$ 47.6 million). It was made effective on April 6, 1990, and closed on June 30, 1999, after two extensions of the closing date. The Project was designed to have three components: Component I involved the strengthening of national population, health and nutrition (PHN) systems; Component II provided health interventions in ten rural districts; and Component III was planned to cover similar interventions in urban Dar es Salaam. Eventually, Component III was spun off as parallel-financed set of activities funded by the Swiss Agency for Development and Cooperation (SDC).

Project Objectives

2. The objectives of the H&N Project were to raise the quality, coverage and effectiveness of family planning, nutrition and basic health services through provision of support to critical and strategic elements of the PHN sector with particular emphasis on strengthening the institutional capacity for health planning and policy formulation; manpower development and training in the health sector; sustainable provision and financing of pharmaceuticals and medical supplies; control of micronutrient deficiency; implementation of the national population policy; rural primary health care (PHC) through a trial implementation of the revised PHC strategy; and urban PHC through reform and rehabilitation of the urban health system in Dar es Salaam.

Implementation Experience and Results

3. The project suffered from poor quality at entry: it was prepared with very ambitious objectives, complex implementation and coordination arrangements, poorly-phased covenants, and ill-considered cross-conditionalities between different implementing agencies. Weak GOT ownership at the start and poor project management (in part due to lack of previous IDA experience) resulted in poor project performance in the first three years. A midterm review led to project restructuring in 1996, resulting in clearer project direction, more feasible workplans, and more streamlined implementation. MOH staff training early on also contributed to the improved implementation. With the restructuring, planned activities were completed and project objectives were largely achieved. Project achievements in policy reform (health financing and pharmaceuticals) are highly satisfactory and these have begun to yield the expected resource-mobilization

and efficiency impacts. The full range of benefits from these policy changes (in terms of sustainability and continuously improving services) will be realized in the long term. Other areas of project involvement were rated satisfactory including the procurement of drugs, training and manpower development, civil works/rehabilitation, rural PHC services, and health management information system. The implementation of the national population policy, however, was less satisfactory.

4. The closing date was extended twice in recognition of the project's development potential and the much-improved pace of implementation. The project was first extended in June 1996 to complete the activity backlog during the first three years; the second extension in April 1998 was made primarily to complete the pretest of alternative financing schemes and to support the GOT's Health Sector Reform initiatives. Both extensions proved to be warranted. By the original closing date, only 42% of the credit (reckoned in SDRs) had been disbursed; the three-year extension resulted in a cumulative disbursement of 55% so that by project's closing, a total of 97% of project funds had been disbursed. Despite initial difficulties with project management and covenant compliance, all civil works under this project were completed, all the planned training were undertaken, all the drugs and supplies were procured, and all the health financing pretests were carried out.

5. In addition to the poor quality at entry, the project suffered from factors outside the Government's control, including the transfer of the Tanzania portfolio from one World Bank division to another, frequent changes in IDA task manager, and the overall shortage of technical and managerial skills in Tanzania. However, there are factors within GOT's control that could have improved project performance including adequate allocation of counterpart funds, political acceptance of the need to restructure the pharmaceutical subsector, and to institute user fees to generate resources and improve efficiency, swift action to improve project management including contracting of management functions, more adequate planning especially in civil works, and a stronger procurement capacity.

6. Borrower performance showed a slow but consistent improvement in project ownership, management, and capacity building. According to the internal GOT project assessment workshop, project preparation had much to be desired, but project implementation was on the whole satisfactory largely due to the dogged commitment of the implementing agencies, the Ministry of Health (MOH) and the Ministry of Regional Administration and Government (MRALG), to the objectives of the project. Government leadership in the sector increased dramatically as the project matured, donor coordination improved, and MOH's commitment to pursue certain reforms, despite initial Parliamentary difficulties, eventually paid off with key legislative actions in health financing and MSD autonomy. Donor coordination and Government leadership in the sector also showed dramatic improvement during project implementation, paving the way for a multidonor-supported Health Sector Reform Program which the follow-on IDA credit will support.

7. Despite extensive background studies during project identification, Bank performance during project preparation and appraisal were deficient: the Bank's task team could be faulted for designing an overly complex project including cross-ministerial

project responsibility that made coordination difficult; being oblivious to critical project risks (e.g., weak government ownership at the start, cross-conditionalities and covenants that are outside the purview of implementing agencies) and inadequate supervision during the first three years of implementation. Project supervision dramatically improved after the midterm review followed by formal restructuring in 1996, and the entry of a new task team. Thus, overall project supervision was satisfactory, according to the internal GOT assessment workshop as well as the Bank's Quality Assurance Group assessment.

8. Without doubt, the sustainability of the Tanzanian health sector and project-initiated activities more specifically, have been considerably enhanced relative to the situation in the late 1980s when the project was designed. Budget allocations to the health sector have doubled, and there is a significant and increasing source of extra-budgetary revenues from user fees, community health funds, and hopefully a health insurance program for civil servants. Drug and medical supplies are better financed and managed now than in the past. The substantial number of project-trained staff continue to serve in civil service, and there is stronger Government commitment to support human resource development even as it seeks greater cost-sharing for staff undergoing training. Communities have been shown to be a critical element in sustaining health investments and for providing additional resources for the health system. Yet, even with these positive developments, Tanzania remains a poor country, and economic growth is expected to continue at a modest pace. Thus, the Government budget for health and household contributions for health services will remain inadequate for the foreseeable future, and donor support will continue to be needed.

Future Operations and Key Lessons Learned

9. Future IDA operation should preserve and expand the gains achieved under the H&N Project and should continue to assist the GOT in the further development of the health sector, with households, communities, local governments and the private sector having a more active role in the financing, delivery, and/or management of health services. On the basis of this principle, the successor IDA credit, the Health Sector Development Program, is being designed as an Adaptable Program Loan (APL) to support, in coordination with other donors, the Government's HSR Program. The first phase of the 12-year APL focuses on: further strengthening of health service delivery through phased decentralization of health services; further human resource development through the rationalization of training institutions; strengthening of central support systems; and expansion of alternative health financing initiatives.

10. The H&N Project provides the following useful lessons:

- Project preparation should take account of project risks as comprehensively as possible and should reduce the complexity and extent of the project on the basis of the magnitude and probability of these risks.

- The relationship between IDA and the host government during project negotiation should be weighed carefully. Cash-strapped poor countries often find themselves

with little countervailing power and IDA should avoid the temptation to exploit this vulnerability by imposing too many conditionalities detrimental to implementation.

- The involvement of multiple agencies/ministries make project implementation more difficult. Thus, the benefits of an inter-ministry project must be weighed carefully against the cost of coordination.

- Critical policy reforms (e.g., health financing and pharmaceutical sector reforms) should be pursued as project outcomes rather than upfront conditionalities. If certain conditionalities are required, their timing for compliance should be carefully planned depending on the nature and objective of the conditionality, as well as it being reflective of government commitment. Compliance to these covenants and conditionalities should be within the purview of the implementing agencies.

- Project components should be designed with an internal logic behind them and not merely used as baskets to put activities in need of funding. The synergy and mutually reinforcing nature of the project components should be taken into account.

- Economic liberalization and related macroeconomic reforms provide strong underpinnings for sector reforms and significantly enhance their achievement. Analytical and policy work between the two should be done hand in hand and in mutually supportive manner.

- Baseline data and performance targets should be defined at project appraisal. These enhance monitoring of project progress; their absence inhibits supervision and makes impact evaluation virtually impossible. Data gathering pertaining to these indicators should be made an intrinsic part of the project.

- For skill-scarce countries or sectors, training should be conducted as soon as possible so that the project can benefit from staff's acquired management and technical expertise. Procurement should be made a central concern of project management.

- Counterpart funds should be calculated globally for the whole project, rather than on a contract-by-contract basis, and should take into account extra-budgetary resources generated from project-supported initiatives such as user fees, prepayments and membership contributions or premia from risk-pooling or other community health financing schemes, and community inputs into village health initiatives.

PART I: PROJECT IMPLEMENTATION ASSESSMENT

Introduction

1. The Government of Tanzania (GOT) implemented the Health and Nutrition (H&N) Project over a nine-year period from March 6, 1990 to June 30, 1999. It was the first IDA project in the health sector and was prepared during a period of fiscal difficulty. The project saw the transition in Tanzania's economy and the social sectors from its socialist orientation to one relying on a more pluralistic and competitive environment with private medical practice being allowed and with households and communities being accorded a critical role in the demand for health services. The project was extended twice (in June 1996 for two years and again in April 1998 for another year); in the last year, the project was closely linked with the preparation of a follow-on IDA credit, the Health Sector Development Program, within the context of the GOT's Health Sector Reform (HSR) Program to be funded by a consortium of donors and the GOT itself.

Project Objectives

2. The objectives of the H&N Project were to raise the quality, coverage and effectiveness of family planning, nutrition and basic health services through provision of support to critical and strategic elements of the population, health and nutrition (PHN) sector with particular emphasis on strengthening the institutional capacity for health planning and policy formulation; manpower development and training in the health sector; sustainable provision and financing of pharmaceuticals and medical supplies; programs to control micronutrient deficiency; implementation of the national population policy; rural primary health care (PHC); and urban PHC through reform and rehabilitation of the urban health system in Dar es Salaam.

3. To achieve these objectives, three project components were implemented which, in hindsight, proved to be mere pegs to hang unrelated activities for funding, making the project unwieldy. *Component I, Strengthening National PHN Systems* (US$38.5 million, according to the SAR), was based in the Ministry of Health (MOH) and coordinated by the Project Implementation Unit (PIU). It covered health planning, policy formulation and information system; manpower development and training; pharmaceutical and medical supplies financing and procurement; micronutrient deficiency control programs; and national population policy.

4. *Component II, Strengthening Rural PHC* (US$11.6 million in the SAR), was based in the Ministry of Regional Administration and Local Government (MRALG), formerly in the Prime Minister's Office, and coordinated by the Project Support Network (PSN). This component was for the most part amorphous and poorly delineated. It involved the implementation of the then-recently revised PHC Strategy, including community mobilization for PHC, support to village PHC initiatives, rehabilitation and strengthening of health facilities, improved water supplies, strengthening of district health management, improved supply and maintenance systems, rehabilitation of district hospitals, and monitoring and evaluation for feedback to PHC policy formulation. The

component focused on 10 poor and hard-to-reach districts where there was no other donor present. It was also designed to benefit from policy and program innovations in Component I, but the different pace of implementation in these two components as well as the different loci of responsibility made such synergy difficult to achieve.

5. *Component III, Strengthening Urban PHC* (US$11.5 million, in SAR), was planned as parallel-financed set of activities based on the bilateral agreement between the GOT and the SDC. It was implemented by the City Commission as the Dar es Salaam Urban Health Project (DUHP Phase I), supported by expatriate technical advisers. The project covered three urban districts and involved the improvement of management and supply systems, rehabilitation of health facilities, establishment of a maintenance system, and operations research. Although Component III was described in the SAR as part of the H&N Project, it operated as a separate project and was completely spun off by DUHP Phase II.

6. *Evaluation of Project Objectives*: The original project objectives were too ambitious. Some of these objectives were translated too strictly as inflexible project conditionalities and covenants which project managers saw as benchmarks to be met rather than directions to be pursued. A basic design flaw was made in making these policy changes (on user fees and on pharmaceutical reforms) conditions of project disbursement, resulting in stalled activities during the first three years. The absence of outcome measures and baseline data also made it difficult for project managers, the implementing Ministries, and other stakeholders to assess progress. As the 1994 midterm review indicates, the project "was perennially in noncompliance with these covenants, always facing the danger of cancellation under the Bank's effort to restructure its portfolio," and by implication, always facing the risk of not meeting its development objectives. Finally, the project design severely underestimated the political constraints of introducing reforms, the local management and technical capacity to put them in place, and the time it took for policy changes to be implemented once the political constraints have been eased. The midterm review in 1994 and the project restructuring that followed clarified the direction for the project, developed key performance indicators and feasible targets, distinguished project activities that are priority and less priority, provided directives to strengthen coordination between Components I and II, and emphasized health financing initiatives. The restructuring proved to be the project's turning point, paving the way for much better implementation performance.

Achievement of Project Objectives

7. Although little was accomplished during the initial years, the project restructuring expedited many activities from 1996 onwards. As a result, project development objectives were largely achieved by project's end. Project achievements in policy reform are highly satisfactory, impact has been considerable, and the full benefits of these will be realized in the longer term. Other areas were rated satisfactory: supply of pharmaceuticals and reforms in this subsector, training and manpower development, civil works, rural PHC services, and HMIS. However, project support for the implementation of the national population policy was less satisfactory.

Component I: Strengthening National PHN Systems

8. *Health Planning*: Project training inputs were substantial and are bearing fruits in terms of stronger planning at the central MOH and better management by district medical officers (DMOs). In all, 30 persons received Masters degrees in public health, health planning and policy, pharmaceuticals management, construction management, information technology, human resources, and nutrition. No fewer than 66 persons also received short-term training on project management, food fortification, health financing, equipment maintenance, and medical stores management. Most of the project-trained government personnel are still in civil service. Most observers note the much improved planning capacity and more satisfactory policy and technical discussions at MOH and the focus districts compared to the situation at project inception. The project also supported the development of district health planning guidelines which have become standard requirements for government financing of district health services.

9. *Policy Formulation and Health Financing*: Through conditionalities, the project influenced greater budget allocation to the health sector, with the proportion of the budget devoted to health dramatically increasing from 6-7% in the late 1980s to 12% in 1998/99. More importantly, the project enabled the shift in the Tanzanian social-sector paradigm from a free-care government monopoly enshrined in the 1967 Arusha Declaration to a system in which households contribute to the financing of care and the private sector has an important role in service provision. Such change was underpinned by project-supported policy and legislative reforms including Cabinet Paper No. 25/6 (June 25, 1993) establishing the Cost Sharing Program (CSP) in government health facilities, the Parliamentary Act establishing the Medical Stores Department as a semi-autonomous body in 1993 and concomitant reforms in drug supplies and financing, and the draft Cabinet paper on community health funds (CHFs) to make it a national policy, drawing on the pretesting experience in 10 project-supported districts. Another policy achievement was the enactment of the National Health Insurance in April 1999, which will initially cover 50,000 central government employees and their dependents.

10. *Health Management Information System (HMIS)*: The project aimed to support the development of an HMIS to register data from maternal and child health and immunization programs and to eventually cover all programs in all districts. Up to February 1997, progress had been less than expected in this area due to frequent changes in the HMIS workplan. The project itself provided minor financial support; most of the HMIS activities were funded by other donors. During 1997-99, HMIS activities picked up, and modules for PHC were developed and introduced nationwide. All 114 District and 20 Regional Health Management Teams (D/RHMTs) have been trained on the HMIS, 20 regions have computerized their HMIS, and 2 districts are being pilot-tested for computerization. These were made possible by DANIDA (the major donor), the H&N Project, GTZ, and UNICEF. DANIDA plans to conduct an evaluation in December 1999 of the impact of these HMIS initiatives on management capacity; it is also supporting the development of the hospital HMIS module.

11. *Manpower Development*: The project initiated the reform of the Department for Manpower Development and Training through the creation of an Inspectorate Unit responsible for monitoring staff performance as well as the establishment of technical,

administrative and logistics units within each MOH division. The project provided consultants to design the logistics and administrative systems; sponsored staff training programs at central, zonal, and district levels; supported the Continuing Education Division for the upgrading and equipping of 5 of the 6 zonal training centers including provision of textbooks and other learning materials; and funded the completion of the Human Resource Development Plan. The impact of these interventions on service delivery remains to be quantified.

14. *Financing and Procurement of Pharmaceuticals and Medical Supplies*: The project provided 31% of the US$ 32.1 million required to address immediate shortfalls in the supply of medical supplies and drugs. Difficulties were experienced under this subcomponent in the early 1990s due to the stringent project conditionalities that required reforming the institutional structure of CMS and that delayed the disbursement of IDA funds. In September 1993, CMS was made a semi-autonomous Medical Stores Department (MSD) by an Act of Parliament; the new entity was jointly capitalized by IDA, DANIDA and GOT to make it financially viable. GOT reformed drug pricing to reflect replacement costs and directed all government health facilities to channel their drug funds through MSD. The project rehabilitated the central MSD office as well as 5 of the 7 MSD zonal stores, and provided training in procurement and financial control. MSD now has a relatively well-trained management staff that can procure drugs and supplies locally and internationally, selling them at replacement costs. Procurement and distribution are supported by an MIS between center and zonal stores and a transport and logistics system integrated with procurement. While the MSD has established a well-capitalized revolving fund, it suffered from the demand constraints by public health facilities due to the inadequate and erratic funding from the Treasury. To address this issue, the project pilot-tested the Drug Capitalization Program (drug revolving fund) for hospitals. Drug availability has improved dramatically especially in districts with CHFs and facilities with drug revolving funds.

13. A GOT-sponsored external review of MSD in March 1998 suggests that improvements still need to be made in the following areas: (a) Procurement – the introduction of a supplier database, computerized tender scheduling package, and review of quality assurance system are needed to eliminate leakages and wastage; (b) Inventory control - some tracer items were still out of stock 13% of the time, necessitating introduction of new inventory control system; (c) Financing - distribution and personnel costs can be reduced further; (d) Information system – there is a need to build in-house capacity and reduce dependence on consultants. Management problems related to the duplication of functions between MSD's Board of Trustees and the Medical Tender Board have been solved by June 1999.

14. *Micronutrient Deficiency Control Program*: The project supported activities to train rural medical aides in the recognition of clinical requirements for vitamin A and iron; educate the public and promote consumption of foods rich in vitamin A and iron; and conduct research on the effects of vitamin A and iron deficiency on health, as well as studies on the socioeconomic determinants of the consumption of foods rich in vitamin A and iron. Key achievements include the establishment of a micronutrient surveillance system (25 sentinel centers) which generates semestral indicators on nutritional status; the development and distribution of policy guidelines and information, education, and

communication (IEC) materials on the control of micronutrient deficiency to public and private health facilities; training of extension staff on micronutrients in all health units in 24 districts; managerial capacity building; holding of national nutrition workshops and radio campaigns; completion of nutrition research studies; and the diffusion of a more efficient technology in palm-oil extraction. A 1994/95 impact evaluation of this subcomponent in 14 districts in 8 regions provided mixed results: a slight increase in the use of vitamin A capsules but low utilization of ferrous sulfate relative to earlier trends. However, it appears that malnutrition in under-5 children has been considerably reduced, although other non-project interventions could also have helped. The micronutrient program has been mainstreamed in the health system and the Tanzania Food and Nutrition Council (TFNC) enjoys government support.

15. *National Population Policy (NPP)*: In 1990, the Government began implementing the NPP through the Tanzanian Council for Population and Development which was created and received project support through the provision of consultants; supplies, equipment and the renovation of office space; staff training in demography; and a research program on population and development. The National Population Information Center was created in the Planning Commission as a research and resource-information base for population issues. Project support came in the form of books, periodicals, supplies, computer equipment, vehicles, staff training, and consultant services. Annual plans were developed and disseminated, and workshops with parliamentarians and religious groups were held. However, many of the planned activities were never executed, and implementation delays occurred due to frequent changes in the management of the Population Planning Unit (PPU). After the initial spurt of activities, little follow-on work has been done. Thus, this subcomponent was repeatedly rated unsatisfactory and consensus is that outcome has been negligible especially during the second phase of the implementation (1996-98). Overall, project involvement in this area has been minor. One positive outcome of project support is that the PPU is now part of the Planning Commission with a dedicated budget. PPU also managed to implement some of the activities of the population policy under the GOT's Family Planning Program using resources outside the H&N Project.

Component II: Strengthening Rural PHC

16. *Support of Village PHC Initiatives*: Activities in this subcomponent included training of district-level staff in community mobilization, IEC campaigns in selected villages in the 10 focus districts to inform them of the types of support they could get from their district for PHC activities, and district health planning. All of the 10 project districts produced district health plans that have received funding for implementation. Overall, supervision reports indicate positive impact of community involvement in rehabilitating and maintaining primary health facilities. Field reports suggest that communities that actually participated in planning and rehabilitation have a high commitment to and sense of ownership of their primary-care facility. Moreover, health infrastructure that relied partly on village funds appear to be better maintained.

17. Village-level PHC civil works include 34 shallow wells, 16 grain storage facilities, and 3 day-care centers. The October 1998 internal evaluation of Component II shows that in general, smaller-scale village level investments appear to have experienced

more difficulties relative to larger-scale investments. For instance, most of the shallow wells have dried up. Also, most of the community-involvement projects (chosen by villagers themselves) has focused on rehabilitation of health facilities at the expense of nutrition-related activities, e.g., fish farming, seed oil extraction, vegetable and fruit gardening, or day-care centers. Finally, training was only implemented up to the ward level and did not go deeper to the grassroots.

18. *Strengthening the District PHC System*: This component involved the rehabilitation and maintenance of 87 dispensaries and 22 rural health centers using community based approaches in 10 districts. Earmarked equipment were mostly in place. The subcomponent also involved strengthening the district health management team (DHMT) through training in community mobilization, management, planning, and financial control (5 DMOs and 1 RMO were trained, all have been promoted); provision of one vehicle for each of the 10 districts; provision of bicycles and other forms of transport to key staff; provision of office furniture and supplies for the DHMT; and strengthening of the facility maintenance workshops through the provision of tools, equipment and supplies. While many of the planned outcomes were realized - all of the project districts now have health plans - supervision reports for Singida, Iramba, Igunga, and Nzega indicate that a number of problems remain including bat infestation of dispensary roofs, poor water provision, underutilized kitchen facilities, and intermittent undersupply of drugs especially for chloroquine-resistant malaria and schistosomiasis. Many health centers have reported increased utilization, but some have figures lower than expected.

19. *Strengthening the District Health Referral System*: This component involved the rehabilitation and equipping of 10 regional/district hospitals. The districts were selected based on poverty indicators and the absence of any other donor supporting the district. All physical rehabilitation was completed and earmarked equipment and furniture are in place. However, some of the hospital instruments and equipment procured appear to be of substandard quality. Also, problems remain regarding shortfalls of staff in some rehabilitated facilities.

Component III: Dar Es Salaam Urban Health Project (DUHP)

20. DUHP was implemented in three phases between 1990 and 2000. Phase 1 (1991 to mid-1993) focused on the rehabilitation of facilities in poorest state, equipping and provision of medical supplies to these facilities, and staff training. In Phase II (mid-1993 to 1996), better-off buildings were repaired, and IEC was introduced to enhance access. Cost sharing was also introduced. Although staff salaries remained, staff morale significantly improved due in part to the better workplace and working conditions. In Phase III (1996-2000), the remaining batch of facilities were repaired. Three district-focused roving maintenance teams were organized, each team consisting of one full-time technician and four artisans (electrical, civil works, plumbing, carpentry), which proved to be successful in keeping facilities in good repair. In the mid-1990s, long before the Local Government Reform (LGR) Program was geared for implementation, DUHP proposed alternative organizational forms to devolve health services. The organogram involving facility boards and district health boards was approved by MOH and MRALG and is in keeping with both the HSR and LGR. Board members are chosen from actual

users of the health facilities (not necessarily influential persons) and serve a term of one year on a voluntary basis.

21. DUHP's outcomes are quite impressive. In all, 60 urban health facilities (dispensaries, health centers and district hospitals) were rehabilitated, staffed, and supplied. The rehabilitation program combined quality and cost effectiveness, i.e., the average cost for the rehabilitation of a dispensary stands at about Tsh 16 million, which seems reasonable given the size of the structure and the amount of work done. The roving teams are keeping facilities well maintained; evaluation reports indicate staff satisfaction with their state of repair. A pilot drug revolving fund at dispensaries appears working well. DUHP has also provided working models of Facility Boards and District Health Boards which are very active. Each District Health Board now holds its own meetings; receives reports from all facilities in the district; formulates the district's health plan; develops the budget; and allocates health expenditures within the urban district. The project has thus successfully established an annual process resulting in the production of comprehensive but standardized district health plans.

Implementation Experience

22. Overall, the H&N Project is rated satisfactory and all of the planned activities were eventually carried out. However, implementation in the early years was unsatisfactory due to poor quality at entry (see below). The project enjoyed a satisfactory rating in the mid-1990s with the revamped effort by the Government, a new task team of the Bank, and project restructuring. However, the project reverted back to unsatisfactory status in 1996/97 due to problems with counterpart funds, delays in civil works, the stalled rehabilitation of the MSD, and inability to disburse the second and third portion for pharmaceuticals due to noncompliance to a legal covenant. Most of these problems have been resolved by 1997, paving the way for satisfactory implementation for the rest of the project's life.

23. *Quality at Entry*: For the first three years, implementation was unsatisfactory due to weak project management and problems with procurement, audit compliance, and compliance with legal covenants which were made as cross-conditionalities, making implementation of one component dependent upon the other. The project also suffered from inadequate supervision from IDA due to frequent changes in the task manager. Poor handling by IDA management of the transfer of Tanzania from the Southern to the Eastern Africa country department also contributed to poor project supervision during this period. In hindsight, "quality at entry was unsatisfactory," according to a World Bank Quality Assessment Group report, and "there seems to be general agreement among all parties, including the government and earlier project managers, that the project design was too complex" for a sector that had no previous experience managing an IDA credit, and faced serious scarcity in project management skills. Moreover, ownership of the project was very limited, if at all, at project inception. Staff who have institutional memory of the project stated that no stakeholder consultations were held, and that the GOT was in a highly vulnerable position due to a serious need for foreign exchange to purchase drugs. In the Quality Assurance Group's view, the project was presented to the IDA Board prematurely, "possibly in response to perceived pressure to lend".

24. *Extension of Closing Date*: The Bank's and the GOT's recognition of the project's development potential, as well as the much-improved pace of implementation, provided the rationale for the two extensions of the closing date. The task team recognized that the large overhang of activities from 1990-94 meant that the project would not disburse fully by the original closing date. Thus, the project was extended in 1996 for two years until June 1998 in order to complete planned activities. At the same time, the project was restructured to accommodate the new health financing innovations developed during the project as well as to support Government initiatives for health sector reforms. The second extension, made in April 1998, was premised primarily on the need to complete the pretest of alternative financing schemes and support operationalization of GOT's health sector reform along the lines of a sector wide approach. Although it was clear that there would be an unspent balance at the end of the project, the Bank made a deliberate decision not to make any cancellation at the time of extension to allow for flexibility to support the pilots that are innovative but financially unpredictable in nature. Both extensions proved to be warranted: the backlog of activities were all completed, the health financing pretests were successfully carried out, and the project served to facilitate the development of sector-wide program.

25. *Project Management*: Project management initially suffered from serious weaknesses including poor understanding of the project concept, weak project coordination between PIU/Component I which was based in MOH, PSN/Component II which was based in PMO/MRALG, and other implementing agencies (TFNC, PPU and CMS); inadequate staffing; changes in MOH leadership and project coordinators; lack of basic office procedures, annual work planning, and budgeting processes; and inadequate understanding of Bank procedures. Midway through the project, these problems had been largely addressed through intensive staff training, hiring of more experienced project coordinator (the third and last), computerization of accounting functions, and GOT's persistent effort in operationalizing the project concept.

26. *Procurement*: Procurement, especially international competitive bidding (ICB), was difficult in the early years owing to project staff's inexperience and lack of familiarity with IDA rules and procedures. Although MOH capacity to procure drugs internationally has improved, similar capacity to procure medical equipment and instruments need to be further strengthened, based on one experience (Tender No. 7 of 1997/98) that resulted in the entry of less-than-qualified suppliers and the importation of some substandard goods. In this regard, there is a need to develop better and more stringent specifications and to strengthen Tanzania's currently limited pre-shipment and post-shipment inspection capacity. Selective procurement based on prequalified bidders need to be explored, and in fact this was the GOT Tender Board's preferred route for Tender No. 7 but was prevailed upon by IDA to go through ICB. Procurement of technical assistance still leaves much to be desired, especially for quality- and cost-based selection, and this has to be addressed in the follow-on IDA credit through more intensive capacity building, or in the interim, through a procurement agent. Project management also informed IDA that in certain cases, operating through IDA-mandated letters of credit was more expensive and laborious (due to the excessively high fees charged by local banks) than through direct payment against shipping documents.

27. *Disbursement and Financial Management*: Due to problems with project management, disbursement-related covenant compliance, and generally poor work planning and budgeting, the rate of disbursements was very low for the first four years; only about a quarter of the credit (reckoned in SDRs) was disbursed during that period. The last five years, however, have been satisfactory as the turn-around time for workplan development and IDA approval was expedited, major covenants were met, and project management was dramatically improved. By closing date, 97% of the credit had been disbursed. In terms of financial management, all audit reports were submitted to the Controller and Auditor-General. The manual accounting system delayed submission of financial reports in the early years, but the computerization of the accounting system (using a simple spreadsheet) made financial reports more readily available. Financial management was generally adequate; a statement of expenses is being finalized.

28. *Counterpart Funds*: GOT had difficulty meeting its counterpart-fund obligations under the project in 1994-96 due to fiscal crises. Given that most African countries are prone to this problem, project managers have proposed that in the future, other in-country resources should be counted as counterpart funds, including user fees from cost recovery programs; fees from drug revolving funds; prepayment contributions in community health funds; membership premia under health insurance programs; and in-kind community contributions in the rehabilitation of facilities. The policy on what constitutes counterpart funds should be reviewed.

29. *Civil Works*: Although the project was not supposed to finance new construction, the absence of a thorough technical evaluation of the project's rehabilitation program resulted in the setting up of new structures which were deemed a technical necessity. Project preparation also failed to come up with unit-cost estimates for rehabilitation; these had to be generated during project implementation itself, but once they were developed (Tsh 10 million for a dispensary; Tsh 38 million for a health center; and Tsh 200 million for a district hospital), they proved to be useful negotiating tools with contractors. In some cases, the problems resulting from inadequate planning or poor performance of contractors led to several amendments of contracts and delayed completion of works. In the late 1990s, delay was also due to El Nino rains resulting in the poor accessibility of project sites. International contractors sometimes did work of inferior quality, according to project management.

30. *Project Monitoring*: The lack of baseline data severely constrained project managers' and Bank staff's understanding of what the project is about and what it is supposed to do. There were no simple indicators or targets with which to measure progress. Lack of household and facility-level baseline data made the assessment of impact virtually impossible. The project was "retrofitted" in 1997 through the development of a logical framework, and this assisted in the preparation of the ICR. An end-of-project evaluation by an external team of consultants is planned to take place in early 2000 which should provide information on the impact of project interventions.

Major Factors Affecting the Project

31. *Factors Outside Government Control*: (a) Poor quality at entry, resulting in poor implementation at the outset, can be traced in part to Bank pressure to lend as much as

the Government's lack of readiness for the project, a finding highlighted under the QAG review. (b) Project supervision also suffered from the transfer, in the early 1990s, of the Tanzania portfolio from one World Bank division to another. (c) Scarcity of technical and managerial skills of the kind required for the project was, and continues to be, a problem in Tanzania, and not one that the Government could have easily addressed.

32. *Factors Within Government Control*: (a) The intermittent budgetary constraints accounted for the inadequate allocation of counterpart funds to the project especially in the mid-1990s resulting in project implementation delays. (b) The reform process could have moved much faster if not for the initial political resistance to eliminate the government pharmaceutical monopoly and to implement cost sharing. As a result, major delays were experienced in the approval of the long term health financing strategy, the action plan on the domestic pharmaceutical industry, and reforms in drug pricing, financing, budgeting, and procurement. (c) Project management and coordination could have been improved much earlier, but PIU remained weak for most of the early years of the project. Recommendations were made to contract out some of the management tasks to outsiders including expatriates, but these were largely ignored. (d) More adequate planning, especially in the civil works component, could have prevented delays and improved contractor performance. (e) Stronger procurement capacity could have prevented the importation of inferior medical equipment and instruments.

Sustainability of Project Activities

33. Largely as a result of the change in health policy, GOT representatives expressed greater confidence over the sustainability of activities supported by the project especially in alternative health financing schemes and pharmaceutical reforms. However, the continued implementation of HRD, HMIS, and rural PHC activities hinges on the robustness of the GOT health budget and therefore on the Tanzanian economy.

34. In terms of health financing, the CSP in government hospitals is well established; CHFs have gained support from the political leadership as well as households; the hospital drug revolving funds promise a more sustainable drug financing and supply pending resolution of policy constraints on cost recovery; and the NHI program for civil servants offers opportunity for greater cost recovery in lieu of the current arrangement of direct government subsidy. Modest cost sharing is also being implemented in training programs, though a more intensified cost recovery effort as well as adoption of other revenue mechanisms may be called for. Likewise, budget allocation to the health sector has dramatically increased. There is certainly a better prognosis for financial sustainability of the Tanzanian health system than it was at the onset of the H&N Project.

35. Major activities in the HRD Plan are of uncertain sustainability. Firstly, the Plan's implementation will continue to be highly reliant on external donors especially the training of DHMTs which has been made more urgent with the devolution of health services, and the MPH training of district medical officers. Secondly, the zonal training centers continue to suffer from the lack qualified staff, inadequate budget for maintenance and selective upgrading of zonal training centers, and lack of funds for the purchase of books and other learning materials.

36. HMIS activities are also likely to continue relying on donor support. In the medium term, the newly-signed DANIDA Health Sector Program Support, Phase 2 will provide Tsh 270 million annually until 2003 for logistics and equipment support. However, the longer-term sustainability of these activities is not ensured since the recurrent budget for supplies and other key inputs is inadequate. Decentralization also poses a challenge to HMIS in that local authorities need to be persuaded to include HMIS supplies in the district budget. Regional-level HMIS implementation may also be adversely affected by decentralization.

37. The institutional and financial sustainability of drug supplies in Tanzania is much better now than it was a decade ago. With respect to the sustainability of the Hospital Drug Capitalization Program, strengthening the capacity in hospitals (e.g., management and accounting of drug revolving fund revenues, better prescription and dispensing practice) would be critical, which should be dealt with in the next IDA credit. In addition, the existing policy of 50% cost recovery under the CSP, as well as the current absence of a mechanism for the Treasury to reimburse health facilities' expenses for drugs dispensed to waived and exempted patients, may inhibit the development of a fully refinancing mechanism. This issue certainly needs to be addressed in the planned program evaluation in January 2000. Short of a full cost-recovery policy for drugs, additional budgetary allocation is needed for the shortfall.

38. Rural PHC activities have mixed sustainability prospects. Institutional sustainability is being enhanced with the adoption of district rolling health plans in the 10 districts; the increasing GOT commitment to support DMOs' Master's training in public health and management; and the planned revision of the existing PHC strategy that will explicitly recognize the level of resources as a fundamental planning parameter, in addition to health patterns, technology, and management structure. Ranged against these positive factors are the continuing inadequacy of maintenance budget for rehabilitated PHC facilities and the lack of funding for PHC community mobilization. Some communities have already mobilized their maintenance funds, and the district block grants planned under the HSR Program as well as the CHFs can become important financing sources for such maintenance. Overall, these and other factors need to be taken into account in the development of a replication strategy for rural/district PHC, which still needs to be done.

39. Project-rehabilitated and -equipped health facilities also needs to be sustained. At present, the preventive maintenance budget for these facilities is very limited; the number of maintenance technicians is deemed inadequate; and the technically competent ones are often ill-motivated due to low salaries. Inadequate security in some facilities has led to losses of portable medical apparata. Moreover, recurrent funding for lab reagents, x-ray films, and other supplies are, in general, inadequate, thus reducing the usefulness of installed equipment. Districts have been empowered to use revenues from user fees for maintenance upkeep, but these are not enough. GOT needs to set aside a larger proportion of the budget for maintenance as a matter of policy, or if this is infeasible, use alternative mechanisms such as the block grants and the CHFs. In addition, a "maintenance culture" need to be inculcated at all levels. The project did set up preventive maintenance programs in the rehabilitated hospitals, including maintenance workshops for hospitals, but staffing continues to be a problem. Community involvement

in maintenance is critical, and MOH needs to exploit this further. GOT also needs to examine the possibility of securing maintenance staff for health facilities at the district level in line with the overall decentralization policy, possibly under the local council. MOH and district authorities also need to learn the successful and innovative maintenance program implemented under Component III by the Dar es Salaam City Commission.

40. Overall, the sustainability of the health system in Tanzania remains fragile. The combined effects of resource-mobilizing efforts (budgetary as well as extra-budgetary means), as well as the efficiency-enhancing interventions (district planning, stronger facility management), are still not likely to fully sustain the considerable investments made under the H&N Project as well as other donor projects in the sector. It is estimated that the GOT can only provide 39% of the recurrent cost requirements of the existing health system. Serious stock-taking within GOT needs to occur on the optimal size of the health system that the country and its donor-partners can afford. This issue needs to be comprehensively and consistently dealt with in the Health Sector Reform Program, the Civil Service Reform Program, and the Local Government Reform Program that the GOT is undertaking.

Borrower Performance

41. According to the GOT internal assessment workshop, *project preparation* was deficient due to GOT's failure to adequately involve all stakeholders in the process, and inexperience with IDA preparation procedures. The Government also negotiated the project under very difficult circumstances; at that time, it faced a serious fiscal and foreign-exchange crisis making it unable to procure drugs and medical supplies in the international market. Thus, GOT had to accept difficult conditionalities for the use of project funds for drug procurement.

42. *Project implementation* was, on the whole, satisfactory. However, implementation in the first 3-4 years was unsatisfactory due to the project's inherent complexity; difficult coordination among several implementing agencies including MOH, MRALG, PPU, and TFNC; weak project management; and frequent changes in MOH leadership and project coordinators. Compliance with project covenants were considerably delayed because the critical ones (user fees, MSD autonomy) required Parliamentary action. Once the project management issues and policy covenants have been addressed, however, project implementation became satisfactory, especially in the last three years. GOT also successfully built on the achievements and experiences gained from the project to support its more ambitious Health Sector Reform Program.

Bank Performance

43. The amount of background studies was considerable and sector analyses were on the mark, making *project identification* satisfactory. However, the GOT internal assessment workshop rated *project preparation and appraisal* as deficient, echoing similar findings from the QAG review. The project was overly complex with too many components and subcomponents (some not well defined); involved multiple

implementing agencies that made coordination difficult; and entailed covenants that were complex, difficult to achieve, and some outside the purview of the implementing agencies. Quality at entry was poor. Although the project preparation team identified major risks such as weak administrative and technical capacity, poor staff motivation, and uncertain macroeconomic environment, their implications were not sufficiently taken into account. Less obvious risks were not considered, e.g., the sector's socialist background and the political will to transform it, weak GOT commitment to and ownership of the project at the start, and lack of prior IDA involvement in the sector. To make the best of the situation, the first three years were virtually used for ground work and capacity building (formulation of sector and subsector plans, staff training on IDA procedures and specific technical areas, building a constituency within MOH for critical reforms sponsored by the project). As a result of poor preparation, *project supervision* was unsatisfactory in the first three years, according to GOT's internal assessment workshop and the QAG review. Poor preparation was compounded by frequent changes in task managers occasioned by the transfer of Tanzania from the Southern to the Eastern Africa department in the Bank. A new task team took over the project in 1993-94, undertook a midterm review, and on this basis restructured the project. From then on, supervision has turned satisfactory. Thus, overall, supervision over the nine years of the project is rated satisfactory.

Assessment of Project Outcome

44. Project impact on *sector policies* are substantial and will be the project's longer lasting legacy. The GOT has laid the foundation for a more sustainable financing and pluralistic delivery of health services, a difficult task given its socialist background. During the project, the health sector was opened to private medical practice, fees were adopted, and a semi-autonomous pharmaceutical agency was established – reforms aided by the economy-wide structural adjustments, including privatization and fiscal rationalization. It is difficult to measure the impact of these changes in terms of better access, quality of care, and improved health services, especially under continuing economic difficulties and the confounding factor of the AIDS epidemic. There is evidence, however, that access is better in project areas and that quality was enhanced with a more reliable drug supplies and rehabilitated and equipped facilities. The *physical objectives* of the project were substantially met, with all the planned civil works and equipping activities completed. However, given the extent of rehabilitation that needs to be done in Tanzania's 114 districts, the work done in the 10 districts barely scratched the surface.

45. Project impact on *financial objectives* and *institutional development*, though dramatic, were only partially achieved. GOT annual allocation to the health sector almost doubled in the nine years of the project, partly due to project covenants. User fees, pioneered in the project, have had demonstration effects in the education and water sectors. CSP now yields significant financial contributions to the sector (13% of nonsalary recurrent costs); without the project's pushing for this reform, underfunding in the sector would have been more persistent with adverse impact on the access and quality of health services. However, significant amounts of revenue continue to be uncollected (42% to 75%, according to the Revenue Targeting Study). The impact of other alternative

financing schemes designed or pretested in the project remains to be shown; although they have a clear potential for mobilizing additional resources, there are concerns about their high startup and maintenance costs. Some ways of reducing these costs include greater use of local rather than expatriate consultants, better rate negotiation with consultants/staff, a tighter community mobilization and training strategy relying on roving "zonal" teams, and finalizing "best practice" manuals and guidelines so that they can be used more widely in roll-out areas. Project impact on institutional development with respect to MSD is large and yielding benefits, i.e., more reliable drug supply. The impact of enhanced MOH planning capacity is expected to yield improved policy formulation to ensure quality services. However, similar institutional-development impact with respect to district health boards remains to be realized. These boards have been set up in CHF districts but those in the remaining districts are yet to be established. Moreover, hospital management still leaves much to be desired even in focus districts.

Future Operations

46. Future IDA operations should preserve and expand the gains achieved under the H&N Project and should continue to assist the GOT in the further development of the health sector. The successor IDA credit, the Health Sector Development Program (HSDP), is being designed as an Adaptable Program Loan to support, in coordination with other donors, GOT's Health Sector Reform initiatives. The HSDP aims to address the sector-wide capacity and management issues and tackle the negative effects of a fragmented project approach. The first phase of the 12-year project focuses on further strengthening of health service delivery in the context of decentralization and greater focus on cost-effective package of health services; further capacity building and human resource development especially the rationalization of training institutions; strengthening of central support systems in planning and budgeting, regulation, pharmaceutical procurement, and joint donor implementation; and expansion of health financing initiatives including CSP, CHF, drug revolving funds, and health insurance.

Key Lessons Learned

47. The following are the key lessons learned from the project:

- Project preparation should take account of project risks as comprehensively as possible and should reduce the complexity and extent of the project on the basis of the magnitude and probability of these risks. Key risks that should be taken into account are government project ownership, sector leadership, management and technical capacity, and the extent and pace of the reform program.

- The relationship between IDA and the host government during project negotiation should be weighed carefully. Cash-strapped poor countries often find themselves with little countervailing power and IDA should avoid the temptation to exploit this vulnerability by imposing too many conditionalities detrimental to implementation.

- The involvement of multiple agencies/ministries make project implementation more difficult. The separation of implementation responsibilities inhibits accountability,

imposes a heavy burden on coordination, and engenders problems with respect to scheduling of related activities, especially if one agency's activity is contingent upon the completion of another agency's activity. Thus, the benefits of an inter-ministry project must be weighed carefully against the coordination costs.

- Critical policy reforms (e.g., health financing and pharmaceutical sector reforms) should be pursued as project outcomes rather than upfront conditionalities. If certain conditionalities are required, their timing for compliance should be carefully planned depending on the nature and objective of the conditionality, as well as it being reflective of government commitment. Some conditions should be used upfront for negotiation, some are better suited for project effectiveness, and others can be applied for funds disbursement.

- Compliance to these covenants and conditionalities should be within the purview of the implementing agencies. It is counter-productive to make these implementing agencies bear the adverse consequences of noncompliance or prolonged delay in compliance for something that is outside their control.

- Project components should be designed with an internal logic behind them and not merely used as baskets to put activities in need of funding. The synergy and mutually reinforcing nature of the project components should be taken into account.

- Economic liberalization and related macroeconomic reforms provide strong underpinnings for sector reforms and significantly enhance their achievement. Analytical and policy work between the two should be done hand in hand and in mutually supportive manner.

- Baseline data and performance targets should be defined at project appraisal. These enhance monitoring of project progress; their absence inhibits supervision and makes impact evaluation virtually impossible. Data gathering pertaining to these indicators should be made an intrinsic part of the project.

- For skill-scarce countries or sectors, training should be conducted as soon as possible so that the project can benefit from staff's acquired management and technical expertise. Procurement should be made a central concern of project management.

- Counterpart funds should be calculated globally for the whole project, rather than on a contract-by-contract basis, and should take into account extra-budgetary resources generated from project-supported initiatives such as user fees from cost recovery programs, prepayments from community health funds, membership contributions or premia from risk-pooling or prepayment arrangements, and community inputs into village health initiatives.

PART II: STATISTICAL ANNEXES

Table 1 Summary of Assessments

A. Achievement of Objectives	Substantial	Partial	Negligible	Not Applicable
Macro policies				X
Health sector policies	X			
Financial objectives		X		
Institutional development		X		
Physical objectives	X			
Poverty reduction		X		
Gender issues				X
Other social objectives		X		
Environmental objectives				X
Public sector management				X
Private sector development				X

	Likely	Uncertain	Unlikely
B. Project Sustainability		X	

	Highly Satisfactory	Satisfactory	Deficient	Highly Unsatisfactory
C. Bank Performance				
Identification		X		
Preparation assistance			X	
Appraisal			X	
Supervision		X		
D. Borrower Performance				
Preparation			X	
Implementation		X		
Covenant compliance		X		
Operation		X		
E. Assessment of Outcome		X		

Table 2 Related Bank Credits

Credit Title and Amount	Purpose	Year of Approval	Status
Past Operations – None	-	-	-
Following Operations – Health Sector Development Program (TZ-PE-58627)	APL program purpose: To improve access, utilization, quality, and financing of health services through increased efficiency and effectiveness in allocation and use of resources to maximize their impact on health outcomes especially among the poor, women, and children Project development objective (Phase I): To improve resource management and quality of health services through sector reforms and institutional capacity building	March 2000 (planned)	Appraisal mission made in August 1999; under preparation

Table 3 Project Timetable

Steps in Project Cycle	Planned Date	Actual Date
Identification	March 1988	March 1988
Preparation	March 1988	May 1988
Pre-appraisal	July 1988	July 1989
Appraisal	September 1988	October 1989
Negotiations	December 1989	January 1990
Board Presentation	March 1990	March 1990
Signing	March 6, 1990	March 7, 1990
Effectiveness	April 6, 1990	April 6, 1990
Midterm Review	September 19, 1994	September 19 – October 6, 1994
Project Completion	December 31, 1996	December 31, 1999
Credit Closing	June 30, 1996	June 30, 1999

Table 4A Credit Disbursements, Cumulative and Actual in U.S. Dollars

Fiscal Year	SAR Estimates		Actual		Actual Cumulative as % of Credit
	Quarterly (US$ Mn)	Cumulative (US$ Mn)	Quarterly (US$ Mn)	Cumulative (US$ Mn)	
FY 90 Q4	0.20	0.20	0.12	0.12	0.25
FY 91 Q1	0.30	0.50	0.02	0.14	0.29
Q2	0.50	1.00	2.18	2.32	4.87
Q3	10.50	11.50	0.03	2.35	4.94
Q4	1.00	12.50	0.02	2.37	4.98
FY 92 Q1	1.00	13.50	1.67	4.04	8.49
Q2	1.00	14.50	0.00	4.04	8.49
Q3	10.60	25.10	0.02	4.06	8.53
Q4	0.69	25.79	0.13	4.20	8.82
FY 93 Q1	0.60	26.39	0.20	4.39	9.22
Q2	0.60	26.99	0.04	4.43	9.32
Q3	10.28	37.27	0.01	4.44	9.32
Q4	1.20	38.47	0.06	4.50	9.45
FY 94 Q1	1.20	39.67	1.33	5.83	12.25
Q2	1.20	40.87	0.12	5.95	12.50
Q3	0.90	42.07	0.51	6.47	13.60
Q4	0.90	42.97	5.91	12.37	26.00
FY 95 Q1	0.90	43.87	0.38	12.75	26.79
Q2	0.90	44.77	1.38	14.13	29.68
Q3	0.40	45.67	0.71	14.84	31.17
Q4	0.40	46.07	1.84	16.68	35.04
FY 96 Q1	0.40	46.47	2.80	19.49	40.94
Q2	0.40	46.87	0.46	19.94	41.89
Q3	0.09	47.27	1.66	21.60	45.38
Q4	0.09	47.36	0.48	22.08	46.39
FY 97 Q1	0.09	47.45	0.11	22.19	46.62
Q2	0.15	47.60	0.62	22.81	47.92
Q3			3.82	26.63	55.95
Q4			3.10	29.73	62.46
FY 98 Q1			1.00	30.72	64.54
Q2			1.55	32.28	67.80
Q3			1.94	34.21	71.87
Q4			1.17	35.38	74.32
FY 99 Q1			1.86	37.24	78.24
Q2			3.72	40.96	86.05
Q3			1.53	42.49	89.26
Q4			1.92	44.41	93.30
FY 00 Q1			2.88	47.29	99.35
Q2			0.08	47.37	99.52

Note: The percentage of disbursement was calculated using the original total credit amount of US dollar equivalent, i.e., US$ 47.6 million. Due to exchange rate fluctuations which resulted in the increase in the US dollar value of the credit, the figures in this table do not necessarily match those of the SDR disbursement table.

Table 4B Credit Disbursements, Quarterly and Cumulative in SDRs

Fiscal Year	Quarterly (US$ Million)	Cumulative (US$ Million)
FY 90 Q4	0.10	0.10
FY 91 Q1	0.01	0.11
Q2	1.51	1.62
Q3	0.02	1.64
Q4	0.01	1.66
FY 92 Q1	1.26	2.92
Q2	0.00	2.92
Q3	0.01	2.93
Q4	1.00	3.03
FY 93 Q1	1.32	3.16
Q2	0.03	3.19
Q3	0.01	3.20
Q4	0.04	3.24
FY 94 Q1	1.00	4.18
Q2	0.08	4.27
Q3	0.37	4.64
Q4	4.17	8.81
FY 95 Q1	0.26	9.08
Q2	0.95	10.02
Q3	0.48	10.50
Q4	1.17	11.67
FY 96 Q1	1.86	13.53
Q2	0.31	13.83
Q3	1.13	14.97
Q4	0.33	15.30
FY 97 Q1	0.76	15.38
Q2	0.43	15.81
Q3	2.73	18.54
Q4	2.24	20.78
FY 98 Q1	0.73	21.51
Q2	1.13	22.64
Q3	1.44	24.08
Q4	0.87	24.95
FY 99 Q1	1.39	26.34
Q2	2.65	28.99
Q3	1.10	30.09
Q4	1.42	31.51
FY 00 Q1	2.12	33.63
Q2	0.06	33.69

Disbursement Profile for Tanzania Health and Nutrition Credit

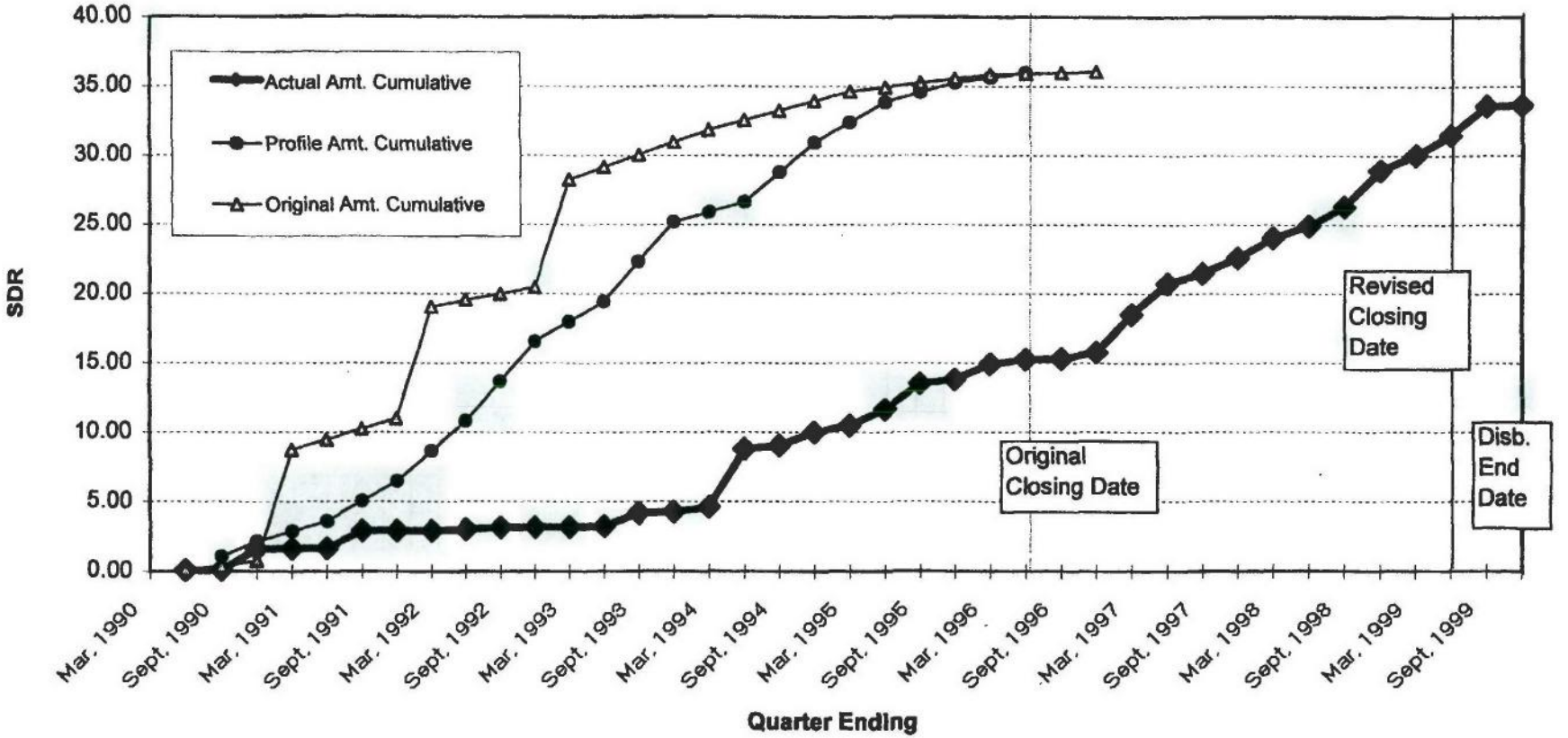

Table 5 Key Indicators of Project Implementation

Subcomponent	Cate-gory	Unit	Target	EOP Status
Strengthening of Planning and Policy Formulation				
Staff positions filled, staff trained, office equipped and supplied	IB	No. of positions; staff-weeks	6 posts; 66 staff-weeks	All 6 posts filled; 66 staff weeks of training completed; Planing Unit equipped
Establishment of District Health Boards; formulation of district health planning guidelines	IB	No. of boards established and using guidelines	5	All 10 project focus districts have DHBs; district planning guidelines in use in all CHF districts
Studies on the Financing of the Health Sector and Pharmaceutical Industry				
Studies on pharmaceutical sector, CSP, NHI, and CHF	O	N.A.	N.A.	13 studies completed for pharmaceuticals, NHI, CSP and CHF and provided basis for reforms
Health Management Information System				
HMIS operational	IB	No. of regions	20	All 20 RHMTs and 104 DHMTs provided with HMIS training, with support from various donors
Policy Reforms in Health Financing				
CSP implementation	O	No. of districts	10	Fees now collected at all facilities in all 104 districts
CHF pretesting	O	No. of districts	10	10 districts pretested and ongoing; more CHF districts planned
NHI design	O	Yes/No	Yes	Parliament enacted NHI law in April 1999
Strengthening of DMDT				
Creation of Inspectorate Unit and development of HRD Plan	IB	Yes/No	Yes	Unit established; Plan completed; 4 principals and 7 staff trained
Strengthening of Training Schools				
Training schools equipped, supplied, and upgraded to zonal training centers	P	5	5	All 5 zonal training centers rehabilitated, but still lack qualified staff
Pharmaceutical Management and Financing				
Transformation of CMS into autonomous MSD	IB	Yes/No	Yes	Parliamentary Act provided MSD autonomy; MSD recapitalized; cost policy changed; new management took over; 42 staff trained

Table 5 Key Indicators of Project Implementation (Continuation)

Subcomponent	Cate-gory	Unit	Target	EOP Status
Provision of Pharmaceutical and Medical Supplies				
Procurement of drugs and supplies	P	US$ Mn	28.00	In all, US$18.79 Mn of drugs were procured
MSD Rehabilitation				
Physical rehabilitation of MSD	P	1+7	1+7	The central office and 7 zonal stores were rehabilitated
Micronutrient Deficiency Control Program				
Development of policy guidelines and IEC materials, training, and awareness campaigns	O; IB	Yes/No	Yes	All planned activities completed; in addition, surveillance system established
National Population Policy				
Creation of NPIC	IB	Yes/No	Yes	Population Planning Unit now part of Planning Commission
District Support and Community PHC Initiatives				
PHC construction	P	No.	N.A.	34 shallow wells; 16 grain storage facilities; 3 day-care centers constructed
Strengthening the District PHC System				
Rehabilitation of dispensaries and health centers	P	No.	N.A.	87 dispensaries; 22 health centers rehabilitated
Strengthening the District Referral System				
Rehabilitation of district hospitals	P	No.	10	10 hospitals rehabilitated

Key: IB=institution building; P=physical; O=others. This table continues next page.

Table 6 Key Indicators of Project Operation

Project Impact to be Maintained	Follow-up Actions Being Taken	Outstanding Issues	Planned Actions
Health planning and policy formulation	Reforms including decentralization to be sustained and expanded under the more ambitious Health Sector Reform Program, with GOT and multi-donor support	Devolution of health services, including fiscal responsibility	Implementation in initial 35 districts
Health management information system	Continuing support to HMIS logistics and equipment to be provided by DANIDA	Recurrent cost funding for stationery and supplies	Provision in the GOT budget
Cost sharing program	Program maintenance and further strengthening of financial management	Impact of fiscal decentralization on CSP	Formulation of policy guidelines on use of fee revenues generated by facilities under local authorities
Community health funds	Pretest for urban CHF; baseline survey of rural districts where CHF will be replicated	High CHF startup and maintenance costs	Scaling up rural CHF to more districts; closer analysis of startup and maintenance costs with the view of further reducing them
National health insurance	Development of fee structure and payment scheme in June 1999; planned program launching in January 2000; appointment of NHIF Board and recruitment of Executive Management Team	Development and installation of claims processing, accreditation, and other systems; ensuring that administrative costs do not go beyond statutory 12% of revenue collection	PPF-funded technical assistance to develop and install systems; Board and management decision on an acceptable level of administrative costs
Manpower development and training	Implementation of the HRD Plan	Insufficient GOT resources to fund the HRD Plan	Donor assistance is being sought to fill the resource gap.
Pharmaceutical management and financing	Maintenance of MSD	Uncertain sustainability of hospital drug capitalization program due to less-than-full cost recovery of drugs	Evaluation of hospital drug revolving funds planned; policy change of current cost sharing policy on drugs is required
Micronutrient deficiency control program	Program maintenance		Provision of recurrent cost to TFNC
National population policy	None	None	None
District support and community PHC initiatives	Maintenance of buildings & equipment	Inadequate budget for maintenance	Provision of more budgetary resources for maintenance
Strengthening district referral system	Maintenance of buildings & equipment	Inadequate budget for maintenance	Provision of more budgetary resources for maintenance

Table 7A Studies Conducted Under the Project

Title, Purpose and Date of Study	Consultants	Status	Impact of Study
Development of District Health Planning Guidelines (1993)	Prof. Kielman	C	In use in all districts
Plan for Strengthening the Permanent Secretary's Office (1993)	M.S. Khan Construction	C	MOH Bldg. Rehabilitated
	Business Electronics	C	Telephone communication improved
Study of the Pharmaceutical and Medical Supplies Sector (1994)	SGV & Co.	C	Inputted into masterplan
Establishment of Financial Accounting and Office Management Systems (1994)	Massawe & Co.	C	Improved project management
Finalization of Health Sector Reform Action Plan, 1996-99 (1996)	Ramses Kumbuya	C	Inputted into HSR Program
Review of Health Sector Reforms (1996)	Randall Bovberg	C	Part of HSR Project development
Preparation of Health Sector Reform Project (1996)	Benson Obonyo	C	Inputted into new project design
Costing of Basic Health Services Package for Igunga District (1996)	E. Mkusa	C	Development of CHF prepayment and fee schedules
Review of Community Health Fund in Igunga (1997)	Prof. P.R. Hiza	C	Monitoring to improve pretesting and design
Development of Indicators and Baseline Survey of CHF Pretest in Igunga (1997)	Tanzania Food and Nutrition Council (TFNC)	C	Baseline information for CHF setup
Qualitative Assessment of CHF (1998)	Andrea Robles	C	Evaluation to improve design
CHF Baseline Survey of Six Districts (1998)	TFNC	C	Baseline information for CHF setup
Development of CHF Guidelines (1998)	Merit Int'l	C	
Development of Fee Structure; Alternative Provider Payment Scheme for the NHI Program (1998)	Both by Management Sciences for Health	C	Inputted into NHI design
Five-Year Plan for Human Resources for Health (1996)	MOH-DANIDA	C	Inputted into HRD Plan
Restructuring of the Department of Training and Manpower Development (DTMT) (1996)	Management Assistance for Health and Population	C	Organizational reform of MOH
Design of the Capitalization Program for Hospital Pharmacies (1997)	Chiel Lidjsman	C	To be evaluated

C=completed

Table 7B Long Term Training Sponsored Under the Project

Person	Degree	Year	Where	Duration	Status
S.M. Kimboka	M. Sc. Human Nutrition	91/92	UK	12 mos.	C
J.O. Mtalo	M. Sc. Architecture	91/92	UK	12 mos.	C
M. Mapunda	M. Sc. Health Planning	91/92	UK	12 mos.	C
M. Kimaro	Postgraduate Diploma in Quality Assurance	91/92	UK	12 mos.	C
E.P. Ngowi	M. A. Construction Management	92/93	Australia	18 mos.	C
O. Abdallah	Diploma in Computer Processing	92/93	U.S.	9 mos.	C
W. Yohana	M. Sc. Medical Statistics	92/93	U.K.	12 mos.	C
R. Kikuli	M. A. Health Planning and Policy	92/93	U.K.	12 mos.	C
D. Mwakasungula	M. A. Architecture	93/94	U.K.	12 mos.	C
E. Mwakalukwa	M. A. Human Resources	94/95	U.K.	12 mos.	C
J. Lugoi	M. A. Medical Education	94/95	U.K.	12 mos.	C
M. Magomi	Masters in Public Health	94/95	U.K.	12 mos.	C
M. Matome	M. A. Education for PHC	94/95	U.K.	12 mos.	C
P. Kasoni	Advanced Diploma in PHC	94/95	U.K.	12 mos.	C
M. Sigonda Ndomondo	M. Sc. Pharmaceutical Services & Medicine Control	94/95	U.K.	12 mos.	C
G. Mungure	Masters in Business Administration	95/96	U.K.	12 mos.	C
N. Mnzava	M. Sc. Health Planning	95/96	U.K.	12 mos.	C
J. Sendoro	M. A. Health Planning, Policy and Management	95/96	U.K.	12 mos.	C
S.J. Chombo	Advanced Diploma in PHC	95/96	U.K.	12 mos.	C
A. A. Janja	M. Sc. Medical Education	95/96	U.K.	12 mos.	C
H. Laay	Financial Management	95/96	U.K.	9 mos.	C
Z. Msuya	M. Sc. Pharmaceutical Analysis	96/97	U.K.	12 mos.	C
S.T. Mosha	M. Sc. Pharmaceutical Analysis	96/97	U.K.	12 mos.	C
L. Mfalila	Health Care Management	96/97	U.K.	12 mos.	C
R. Mkumbo	M. Sc. Health Planning & Management	96/97	U.K.	12 mos.	C
G. Sangana	Masters in Public Health	97/98	U.K.	12 mos.	C
C. Feruzi	Masters in Public Health	97/98	U.K.	12 mos.	C
P.J. Mbena	Masters in Public Health	97/98	Belgium	9 mos.	C
H. Ngonyani	Masters in Public Health	97/98	Belgium	9 mos.	C
E. Mwegoha	Masters in Medical Education	97/98	U.K.	12 mos.	C

C=completed

Table 7C Short Term Training Sponsored Under the Project

Person	Course	Year	Where	Status
G. Mungure	Procurement	Aug. 90	Italy	C
S. Manyama	Health Planning and Management	Jan.-Apr. 91	U.S.	C
R.R. Kitwenga	Nutritional Anemia	Jan.-Apr. 91	U.K.	C
E. Manumbu	Health Care Financing	Sep.-Dec. 91	U.S.	C
J. Goodluck	Computer Programming	June-Dec. 91	U.K.	C
Dr. Mponezya	Health Care in Developing Countries	May-Aug. 91	U.S.	C
E.K. Ndossi	Manpower Studies	Sep.-Dec. 91	U.K.	C
R. Kikuli	Project Management	Sep.-Nov. 91	U.S.	C
Mrs. Mullokozi	Vitamin A Analysis	Jan.-Apr. 92	U.S.	C
S. Paschal	Management Methods for Health	Feb.-May	U.S.	C
J. Chitalika	Programming and Data Processing	Aug.-Dec. 92	U.K.	C
L. Msele	Vegetable Production	Aug.-Nov. 93	Netherlands	C
M.F. Kweba	Food Fortification	Sep.-Dec. 92	U.S.	C
S.J. Maganga	Food Fortification	Sep.-Dec. 92	U.S.	C
C.R. Temalilwa	Food Fortification	Sep.-Dec. 92	U.S.	C
Z. Lukmanji	Epidemiology	Sep. 92	U.K./U.S.	C
A.B. Sanga	Micronutrient Deficiency Control	Sep.-Dec. 92	U.S.	C
U.P.K. Tenende	Population Data Analysis	Mar.-July 93	U.S.	C
S.E. Ngatunga	Health Sector Reform	Apr.-July 93	U.K.	C
A. Juma	Equipment Maintenance	Mar.-May 93	U.K.	C
K.A. Mmuni	Managing Health Programs	June-Aug. 93	U.S.	C
E. Malibiche	Advanced Computer Studies and Management	June-Aug. 94	Swaziland	C
C. Kitachang'wa	Advanced Computer Studies and Management	June-Aug. 94	Swaziland	C
M. Masanja	Advanced Computer Studies and Management	June-Aug. 94	Swaziland	C
B. Gondwe	Advanced Computer Studies and Management	June-Aug. 94	Swaziland	C
T. Chagula	Advanced Computer Studies and Management	June-Aug. 94	Swaziland	C
MSD Staff	Pharmaceuticals Management (Batch 1)	Apr.-May 96	Tanzania	C
MSD Staff	Pharmaceuticals Management (Batch 2)	Aug. 96	Tanzania	C
MSD Staff	Pharmaceuticals Management (Batch 3)	Aug. 96	Tanzania	C
C. Msemo	Purchasing Stock Management	Jan.-Mar. 97	U.K.	C
B. Mkusa	Industrial Training	Jan. 98	U.K.	C
N. Musyani	Population Studies	June 98	Swaziland	C
4 Staff of PS's Office	Procurement Training	n.d.	Swaziland	C
9 Staff of PS's Office	Financial Management	n.d.	Swaziland	C
10 Staff of PS's Office	General Management	n.d.	Swaziland	C
6 Staff of PS's Office	Advanced Computer and Office Management	n.d.	Swaziland	C

C=completed; PS=permanent secretary

Table 7D Workshops, Seminars and Conferences Supported by the Project

Workshop, Seminar or Conference	When	Where	No. of Persons Participating
Demographic and Health Survey	1991/92	U.S.	1 (Musyani)
ESCACON Scientific Conference	1992/93	Mauritius	1
International Conference on Nutrition	1992/93	Geneva, Switzerland	1
Population Conference	1992/93	Senegal	4
Health Strategy Workshop	June 1993	Washington, D.C., U.S.	20
Setting Tomorrow's Agenda Seminar	Sept. 1994	n.d.	2 (Mtulia, Manumbu)
International Conference on Population and Development	Aug. 1994	Cairo, Egypt	6
ESCACON Scientific Conference	Aug. 1994	Seychelles	2
Health Seminar	Sept. 1995	n.d.	n.d.
Health Seminar	Oct. 1995	n.d.	2 (P.P. Mella and R. Mushi)
Health Seminar	Nov. 1995	n.d.	2 (Chagula and Mgondah)
Pharmaceuticals Management Seminar	Feb. 1996	Tanzania	n.d. (MSD Staff)
Pharmaceuticals Management Seminar	Apr. 1996	Tanzania	n.d. (MSD Staff)
Pharmaceuticals Management Seminar	May 1996	Tanzania	n.d. (MSD Staff)
Health Care Financing Seminar	Feb. 1996	Nairobi, Kenya	4 (Manumbu, Njau, Shirima, Minja)
Innovation in Health Care Financing Seminar	Mar. 1997	Washington, D.C., U.S.	2 (Min. Chiduo, PS Mrope)
Setting Tomorrow's Agenda Seminar	Oct. 1997	Washington, D.C., U.S.	5 (Mrope, Manumbu, Njau, Mwizamholya, Kalinga)
Health Policy Seminar	Apr. 1998	London, U.K.	5 (Mbaruku, Kabuma, Sekilasa, Mapunda, and Upunda)
Health Systems Management Seminar	Mar. 1998	Israel	5
Quality Assurance Seminar	Mar. 1998	Uganda	2 (Shija andMbuya)

Table 7E Study Tours Conducted Under the Project

Study Tour	When/Where	Purpose	No. of Persons Participating
National Health Insurance	November 1997: Thailand, the Philippines, and Boston, U.S.A.	To learn about health insurance	9 persons from the Health Insurance Implementation Team
Pharmaceuticals	June 1998: Denmark	Visit Unipack	Board of Trustees and Directors of MSD

Table 7F Rural PHC Civil Works Completed Under the Project

District	Dispensaries	Health Centers	Shallow Wells	Grain Storage	Day Care Centers
Igunga	7	2	-	-	-
Iramba	8	2	3	-	-
Kasulu	9	2	-	-	-
Kibondo	8	3	2	7	-
Kilwa	10	3	8	-	-
Lindi Rural	12	4	-	-	-
Liwale	9	-	-	-	2
Nachingwea	9	-	10	-	1
Nzega	5	4	2	-	-
Singida Rural	10	2	9	9	-
Total	87	22	34	16	3

Table 7G Rehabilitation and Equipping of District Hospitals Under the Project

Facility	Rehabilitation and Equipping
Igunga DH	Construction of new structures which includes 6 wards, laboratory, MCH unit, dental unit, theater, and workshop; provision of water generator and work tools
Iramba DH	Construction of new fence and watchman house; rehabilitation of all hospital wards, mortuary, and dental units; provision of work tools
Kasulu DH	Repair of worn-out leaking water distribution system (pipes and tanks); provision of stand-by generator; fencing; rehabilitation of all existing wards; provision of work tools
Kibondo DH	Construction of staff quarter; rehabilitation of all hospital wards, dental unit, and mortuary; drainage system and water supply
Kilwa DH	Construction of 2 wards, MCH unit, 3 staff houses, watchman's house, 1 underground water tank, 8 underground septic tanks; rehabilitation of 7 staff houses; provision of work tools; provision of generator
Lindi RH	Construction of watchman's house, fence, maintenance workshop; rehabilitation of 11 wards and drainage system; provision of work tools
Liwale DH	Construction of mortuary, dental unit, theatre, and 3 staff quarters; rehabilitation of all hospital wards; fence and water supply system
Nachingwea DH	Construction of maintenance workshop; fencing; septic tanks and soak pits; rehabilitation of all hospital wards, theater, dental unit, mortuary, drainage system; provision of generator and work tools
Nzega DH	Partitioning of 8 patient wards; replacement of tiles with painted corrugated iron sheets; new water and drainage systems; replacement of electric wires; setting up of new maintenance workshops and provision of tools; construction of security house
Singida RH	Construction of new dental unit; rehabilitation of laboratory building; expansion of mortuary; construction of fencing and watchmen's house; construction of rainwater harvesting system; installation of new electric water tank; construction of 12 new septic tanks; provision of work tools

Key: DH=district hospital; RH=regional hospital; MCH=maternal and child health

Table 8 Project Financing

Source	At Appraisal (US$ Million)	% at Appraisal	Actual (US$ Million)	% of Actual
International Development Association	47.60	68.00	47.37	91.50
Gov't of Belgium, DANIDA, ODA, SDC, and UNFPA (Note 1)	15.00	21.43	N.A.	N.A.
Government of Tanzania (Note 2)	7.40	10.57	4.40	8.50
Total	70.0	100.00	51.77	100.00

Notes:
(1) The respective contributions for co-financing would have been as follows: Government of Belgium, US$0.7 million; DANIDA, US$1.3 million; ODA now DfID, US$0.1 million; SDC, US$12.2 million; and UNFPA, US$0.7 million. SDC went on to provide resources for parallel-financed activities under the Dar Es Salaam Urban Health Project (formerly designated as Component III). DANIDA and ODA/DfID also provided parallel-financed activities in pharmaceutical sector, HMIS, Cost Sharing Program.
(2) GOT contributions at appraisal included separate estimates for central government, US$3.1 million; district governments, US$2.5 million; and beneficiaries, US$1.8 million. In the course of project monitoring, only the central government contribution was regularly reported. At project end, this amounted to US$4.4 million.

Table 9A Project Costs by Expenditure Categories, Estimated and Actual

Expenditure Categories	Appraisal Estimates (US$ '000)				Actual Figures (US$ '000)		
	GOT	IDA	Other Donors	Total	GOT	IDA	Total
Civil Works	0.36	5.77	9.16	15.29	1.70	9.95	11.65
Equipment, Vehicles, Materials, Supplies	0.17	9.57	2.05	11.79	0.29	6.61	6.90
Pharmaceuticals and Medical Supplies	0.00	28.01	0.00	28.01	0.68	19.04	19.72
Consultancies	0.01	1.56	2.49	4.06	0.31	7.08	7.39
Training, Travel and Per Diems	1.38	2.20	0.55	4.13	1.32	4.41	5.73
Matching Grant to CHF	-	-	-	-	0.10	0.22	0.30
Other Costs	1.16	0.51	0.64	2.31	-	0.07	0.07
Total	3.08	47.62	14.89	65.59	4.40	47.37	51.77

Table 9B Project Costs by Project Components, Estimated And Actual

Project Components And Subcomponents	Appraisal Estimates (US$ Million)			Actual Figures (US$ Million)		
	GOT	IDA	Total	GOT	IDA	Total
I. Strengthening National PHN Systems						
A. Health Planning and Policy Reforms	0.61	2.03	2.64	0.70	7.66	8.36
B. Manpower Development and Planning	1.01	2.45	3.46	0.36	2.84	3.20
C. Provision of Pharmaceutical and Medical Supplies and MSD Reforms	0.63	30.97	31.60	0.68	21.32	22.00
D. Micronutrient Deficiency Control Program	0.16	1.45	1.61	0.20	1.71	1.91
E. National Population Policy	0.10	0.00	0.10	0.15	0.15	0.30
F. Project Implementation Unit	-	-	-	0.11	1.98	2.09
Subtotal for Comp. I	2.52	36.89	39.41	2.20	35.66	37.86
II. Strengthening Rural Primary Health Care						
A. District Support for Community PHC Initiatives	-	-	-	1.90	6.28	8.18
B. Strengthening District Referral System	-	-	-	0.20	3.04	3.24
C. Project Support Network	-	-	-	0.10	2.38	2.48
Subtotal for Comp. II	0.56	10.24	10.80	2.20	11.70	13.90
Project Preparation Facility	-	0.50	0.50	-	-	-
Grand Total	3.08	47.62	50.71	4.40	47.37	51.77

Notes: A-includes all activities related to health planning and policy reforms (A-1), health management information system (A-2), cost sharing program (A-3), and community health funds and national health insurance (A-4). B–includes all activities related to manpower development and planning (B-1) and the rehabilitation of five zonal training centers (B-2). C–includes all activities related to pharmaceutical management and the reform of the Central Medical Stores (C-1), the provision of pharmaceutical and medical supplies (C-2), and MSD rehabilitation (C-3). Details may not add up to totals due to rounding.

Table 10 Status of Legal Covenants

DCA Refer -ence	Description of Covenant	Type	Status	Ori-ginal Date	Act-ual Date	Comments
Sec. 2b, p.21	6 vacant positions filled in MOH Planning Department: Public Health Specialist, Epidemiologist, Health Economist, Economist	12	CD	July 1, 1993	Sep. 30, 1994	All staff is now in place.
Sec. 3.05, p.6	Long Term Health Financing and Action Plan	11	CD	Apr. 30, 1992	June 30, 1995	GOT instituted cost sharing in July 1994 and has expanded it according to a phased plan. Options for formal sector insurance analyzed and discussed. Pilot testing rural prepayment as of July 1, 1996.
Sec. 3.06, p.6	Review with IDA study of domestic pharmaceuticals industry and agree on action plan	12	CD	July 1, 1992	Mar. 31, 1996	MOH contracted SGV & Co. to do study by end-1994. Draft study January 1995. Impact of study reviewed in Mar.1996. Most study recommended have been acted on.
Sec. 3.03, p.5	Draft Health Manpower Plan submitted to IDA.	12	C	Dec. 31, 1991	June 20, 1996	Plans submitted.
Sec. 3.03, p.5	Commence implementation of Health Manpower Plan	12	CD	July 1, 1992	Oct. 1, 1996	Part of the plan started implementation, e.g., introduction of cost sharing of medical training, streamlining of cadres.
Sec. 3d, p. 13 2c, p. 21 2d, p. 22	Action plan for strengthening Department of Manpower Development and Training; criteria for selecting candidates for external training; disbursement condition for overseas training (Category 1-F)	12	C	N.A.	Oct. 31, 1993	MOH has implemented an acceptable plan.
Sec. 4a, p.13	Satisfactory progress in reforms in pricing, financing budgeting in procurement of pharmaceuticals for Part 1 (condition of disbursement on Category 1-E2).	12,11	CD	June 30, 1992	Dec. 15, 1997	New MSD regulations were disseminated by the GOT Notice No. 348 of Nov. 1, 1996.

Table 10 Status of Legal Covenants (Continued)

DCA Refe-rence	Description of Covenant	Type	Status	Ori-ginal Date	Act-ual Date	Comments
Sec. 4a, p.13	Satisfactory progress in resource mobilization following the Long Term Health Financing Plan in DA 3.05 (p.6). (Condition of disbursement on category 1-E-3).	11,02	C	June 30, 1993	Dec. 15, 1996	A new higher schedule for cost sharing was announced in Dec. 1996 and became effective Jan. 1, 1997. Cabinet approved a proposal for national social insurance in June 1996 and the Parliament approved the National Health Insurance Act in Apr. 1999. The CHF pretest was launched in July 1996, expanded to 6 more districts in 1998, and is being rolled out to additional districts in FY99.
Sec. 3b, p.13	Satisfactory progress with new institutional structure and action plan for Central Medical Stores. Condition of disbursement for Category 1(a)(ii).	12	C		July 1, 1994	A joint pharmaceutical sector review in Feb. 1997 confirmed substantial progress in this area. Some targets in the Master Plan were outperformed.
Sec. 2e, p.22	Tanzania food and nutrition center protocol for external mid-term evaluation of Vitamin A and iron deficiency programs submitted to IDA.	09	CD	June 30, 1991	Jan. 1, 1995	Completed during mid-term review in Oct. 1994.
Sec. 2e. p.22	Tanzania food and nutrition evaluation of Vitamin A and iron deficiency programs completed.	09	CD	Dec. 31, 1992	Jan. 1, 1995	Completed during mid-term review in Oct. 1994, with reviews conducted during regular supervision missions.
Sec. 3b, p.22	District Medical Officer in each district is responsible for supervision implementation of the project in the district.	12,05	C	June 30, 1993		DMOs have taken this responsibility in each district in the project.
Sec. 3c, p. 13; 4d, p. 23	Put officer in charge at District Hospital in order to relieve District Medical Officer of that responsibility.	12, 05	C			Currently the case in all 10 districts.

Table 10 Status of Legal Covenants (Continued)

DCA Reference	Description of Covenant	Type	Status	Original Date	Actual Date	Comments
Sec. 3c, p.13; 4d, p.23	Annual District Health Plan for each participating district submitted in accordance with agreed DHP guidelines. IDA approval required before funds are released to each district. Disbursement condition on payments, by district, beyond the basic package, for each year of the project.	12,05	C	Nov. 30, 1991	-	Waived in DCA; basic package only.
Sec. 3c, p.13; 4b, p.23	Annual District Health Plan for each participating district submitted in accordance with agreed DHP guidelines. IDA approval required before funds released to each district. Disbursement condition on payments, by district, beyond the basic package, for each year of the project.	12,05	C	Nov. 30, 1994	May 30, 1995	A two-year plan through June 30, 1997 was received in a timely manner.
Sec. 4c, p.23	Account No.6 for health is opened, with DMO first signatory agent. Disbursements condition on payments to any particular district each year.	12,03, 05	C			Currently the case in all 10 districts (Feb. 1993).
Sec. 2f, p.22; 4a(I-IV), p.22	Agreed with IDA on revised PHC strategy, with PHC Secretariat.	12	C	Dec. 30, 1990	Jan. 30, 1992	Revised PHC agreed with IDA, developed by PHC Secretariat.
Sec. 2f, p.22; 4a(I-IV), p.22	Agreed with IDA on guidelines for rehabilitation of referral system in the 10 selected districts.	05	C	Dec. 30, 1990		Proposed during the kick-off workshop.

Table 10 Status of Legal Covenants (Continued)

DCA Reference	Description of Covenant	Type	Status	Original Date	Actual Date	Comments
Sec. 2f, p.22	Agreed with IDA on list of criteria for evaluating performance of the 10 selected districts.	05	C	Dec. 30, 1990		First draft provided to Feb. 1993 mission. Application undertaken over the following 6 months. Reviews and adjustments undertaken.
Sec. 2f, p.22; 4a (I-IV), p.22	Agreed with IDA on guidelines for preparation of District Health Plans.	12,05	C	Dec. 30, 1990	Nov. 30, 1998	National District Health Planning Guidelines completed. Subsequently, it was developed into training modules which will be implemented through zonal training centers.
Sec. 4e, p.23	Agreed with IDA on protocols for external evaluation of revised PHC	09	CD	June 30, 1991	Jan. 30, 1998	Terms of reference for external evaluation have been developed.
Sec. 4e, p.23	Results of external evaluation reviewed with IDA.	09	NC	Dec. 31, 1992	June 30, 1999	Due to the extension of the credit, evaluation will be carried out in the first half of 1999.
Sec. 4e, p.23	Increase share of recurrent budget to health sector, satisfactory to IDA.	11	C	June 30, 1991	June 30, 1998	Substantial increase in share of budget, verified by update of PER and SSR.
Sec. 3.04, p.6	Adopt incentives package for Health Sector Staff.	12,04	C	July 1, 1991	Oct. 31, 1992	Revised incentives for health workers implemented through GOT circular in 1990 created many internal problems in the health sector, especially between medical and nonmedical staff. A revised policy was put in place in 1993.
Sec. 5, p.23	Intergovernment agreement with Swiss Development Cooperation for Component III of the project (Urban Health)	05	C	June 30, 1991	June 30, 1991	GOT and SDC have successfully completed phase two and evaluation has been done. SDE agreed to fund phase three (last phase) for another 3 years.

Table 10 Status of Legal Covenants (Continued)

DCA Reference	Description of Covenant	Type	Status	Original Date	Actual Date	Comments
Sec. 1b, p. 21	Joint annual review of the project with GOT and IDA.	05,09	C	May 1, 1991	Oct. 4, 1991	Supervision mission.
Sec. 1b, p.21	Joint annual review of the project with GOT and IDA.	05,09	C	May 1, 1992	July 30, 1992	Supervision mission.
Sec. 1b, p.21	Joint annual review of the Project with GOT and IDA.	05,09	C	May 1, 1993	Sep. 28, 1993	Supervision mission.
Sec. 1b, p.21	Joint annual review of the project with GOT and IDA.	05,09	C	May 1, 1994	Oct. 6, 1994	Supervision mission.
Sec. 1b, p.21	Joint annual review of the project with GOT and IDA.	05,09	CD	May 1, 1995	June 15, 1995	Supervision mission.
Sec. 1b, p.21	Joint annual review of the project with GOT and IDA.	05,09	C	May 1, 1996	Apr. 1, 1996	Supervision mission. Completed ahead of due date.
Sec. 2a, p.21	Staffing of PIU for Component I	05	CD	June 30, 1990	Mar. 8, 1991	All project personnel in place. By Dec. 31, 1994, all project personnel was on leave of absence from civil service. They are employed as consultants to the project until project closing of June 30, 1999.
Sec. 3a, p.22	Project management for Project Support Network for Component II.	05	CD	Dec. 31, 1990	June 30, 1994	A new team was put in place as of July 1, 1998. Hired as consultants up to Dec. 31, 1998.
Sec. 4.01b (II)	Component I: PIU Audited Accounts.	01	CD	Mar. 31, 1992	June 31, 1992	Minor questions from auditor.
Sec. 4.01b (II)	Component I: PIU Audited Accounts.	01	CD	Mar. 31, 1993	July 31, 1993	Minor questions from auditor.
Sec. 4.01b (II)	Component I: PIU Audited Accounts.	01	C	Mar. 31, 1994	Mar. 31, 1994	Minor questions from auditor.
Sec. 4.01b (II)	Component I: PIU Audited Accounts.	01	CD	Mar. 31, 1995	Mar. 31, 1995	Minor questions from auditor.

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Table 10 Status of Legal Covenants (Continued)

DCA Refe-rence	Description of Covenant	Type	Status	Ori-ginal Date	Act-ual Date	Comments
Sec. 4.01b (II)	Component I: PIU Audited Accounts.	01	CD	Mar. 31, 1996	Mar. 1, 1996	Minor questions from auditor. Complied ahead of due date.
Sec. 4.01b (II)	Component I: PIU Audited Accounts.	01	CD	Mar. 31, 1997	Apr. 30, 1997	Minor questions from auditor.
Sec. 4.01b (II)	Component II: PSN Audited Accounts.	01	CD	Mar. 31, 1992	Mar. 31, 1993	Minor questions from auditor.
Sec. 4.01b (II)	Component II: PSN Audited Accounts.	01	CD	Mar. 31, 1993	Mar. 31, 1994	Minor questions from auditor.
Sec. 4.01b (II)	Component II: PSN Audited Accounts.	01	CD	Mar. 31, 1994	Mar. 31, 1995	Minor questions from auditor.
Sec. 4.01b (II)	Component II: PSN Audited Accounts.	01	CD	Mar. 31, 1995	Mar. 31, 1996	Minor questions from auditor.
Sec. 4.01b (II)	Component II: PSN Audited Accounts.	01	CD	Mar. 31, 1996	June 20, 1996	Minor questions from auditor.
Sec. 4.01b (II)	Component II: PSN Audited Accounts.	01	CD	Mar. 31, 1997	Apr. 30, 1997	Minor questions from auditor.
Sec. 3.07, p.6	Adequate budget for project implementation.	04	C	May 1, 1992	May 1, 1992	Counterpart funds not a problem.
Sec. 3.07, p.6	Adequate budget for project implementation	04	C	May 1, 1993	May 1, 1993	Counterpart funds not a problem.
Sec. 3.07, p.6	Adequate budget for project implementation	04	C	May 1, 1994	May 1, 1994	Counterpart funds not a problem.
Sec. 3.07, p.6	Adequate budget for project implementation	04	C	May 1, 1995	May 1, 1995	Counterpart funds not a problem.

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Table 10 Status of Legal Covenants (Continued)

DCA Reference	Description of Covenant	Type	Status	Original Date	Actual Date	Comments
Sec. 4.01b (II)	Component I: PIU Audited Accounts.	01	C	Mar. 31, 1998	Mar. 23, 1998	Reports submitted on Mar. 23, 1998, ahead of due date. Minor questions from auditor.
Sec. 4.01b (II)	Component I: PIU Audited Accounts.	01	NC	Mar. 31, 1999		
Sec. 4.01b (II)	Component II: PSN Audited Accounts.	01	CD	Mar. 31, 1998	Apr. 6, 1998	Minor questions from the auditor.
Sec. 4.01b (II)	Component II: PSN Audited Accounts.	01	NC	Mar. 31, 1999		
Sec. 3.07, p.6	Adequate budget for project implementation.	04	CD	May 1, 1997		
Sec. 1b, p.21	Joint annual review of the Project with GOT and IDA.	05,09	CD	May 1, 1997	July 11, 1997	Supervision mission carried out during June 11 – July 11, 1997.
Sec. 1b, p.21	Joint annual review of the Project with GOT and IDA.	05,09	CD	May 1, 1998	Sep. 4, 1998	Supervision mission carried out during Aug. 17 – Sep. 4, 1998.

Covenant Types: 1=**Accounts/Audits; 2=Financial performance/revenue generation from beneficiaries; 3=Flow and utilization of project funds; 4=Counterpart funding; 5=Management aspects of project or executing agency; 6=Environmental covenants; 7=Involuntary resettlement; 8=Indigenous people; 9=Monitoring, review and reporting; 10=Project implementation not covered by 1-9; 11=Sectoral or cross-sectoral budgetary or other resource allocation; 12=Sectoral or cross-sectoral policy/regulatory/institutional action; 13=Other.**

Present Status: **C=covenant complied with; CD=complied after delay; CP=complied with partially; NC=not complied with.**

Table 11 Compliance with Operational Manual Statements

Statement No. and Title	Comments
OD 10.60 Accounting, Financial Reporting, and Auditing OD 13.10 Borrower Compliance with Audit Covenants	The Bank requires appropriate accounting policies to ensure accountability for all funds of the Borrower and submissions of audited financial statements for each fiscal year from the date agreed at negotiations. Accounts have been maintained for the project. The Bank requires Borrower compliance with audit reporting and details the scope of coverage by the audits. Audits were submitted for all years, though they tended to be delayed.
OD 6.30 Local Cost Financing and Cost Sharing	The Bank expects the Borrower to demonstrate commitment to the project by making a minimum contribution to the project cost (net of taxes and duties) The Borrower's contribution amounted to 8.5% of total project cost, as compared to the projected 20% at appraisal.
OD 13.30 Use of Project Cost Savings	The Bank allows, on an exceptional basis, some or all of the project savings to be used to finance additional project activities not included in the original project description, provided that the implementation of the project is satisfactory (including substantial compliance with the Agreements), the activities proposed have very high priority, and are consistent with project objectives, and that they have been fully appraised by Bank staff, and financing these activities does not violate country limits on cost sharing. Project savings from exchange rate changes and cheaper procurements were reallocated to the different project components and subcomponents.
OD 13.30 Extension of Closing Dates	The Bank may approve for selected disbursements covering only part of a project to permit (a0 implementation of some mutually agreed, high priority contracts; (b) the extension of the validity of letters of credit covered by special commitment; or (c) provision of retention payments, when the conditions for release (e.g., completion of performance tests or expiration of warranty period) are met after the closing date. The Bank allowed 4 months after the project closing date for disbursements retention payments for a number of procurement contracts.
OD 13.55 ICR Preparation	The Borrower prepares and makes available to the Bank its own evaluation on the project's execution and initial operation, cost and benefits, the Bank's and Borrower's performance of their respective obligations under the loan agreement, and the extent to which the purposes of the loan were achieved; adopts a plan for the operational phase of the project; and assists the Bank in ICR preparation. The MOH and MORALG held a two-day internal assessment workshop of the project (the summary of the report is attached to the ICR) and participated in the ICR preparation with the Bank team.

Table 12A Actual Bank Staff Inputs

Stage of Project Cycle	Costs US$ '000
Preparation to Appraisal	246.2
Appraisal	38.3
Negotiation Through Board Approval	19.1
Supervision	1,144.5
Completion	-
Total	1,448.1

Table 12B Bank Missions

Stage of Project Cycle	Implement'n Status	Dev't Impact	No. Per-sons	Person-days	Skills Represented	Observations
Identification 3/1988	-	-	n.a.	n.a.	n.a.	
Preparation 5/1988	-	-	n.a.	n.a.	n.a.	
Preappraisal 7/1989	-	-	n.a.	n.a.	n.a.	
Appraisal Mission 10 to 11/1989	-	-	6	n.a.	Specialists in public health, manpower development, pharmaceuticals, and nutrition	
Supervision Mission 9/11-9/20, 1990	3	2	2	10	Economist, public health specialist	Comp. II is rated satisfactory but Comp. I shows serious weaknesses. Policy reforms in the pharmaceutical sector not implemented. MOH reorganization affects project stability.
Spn. Mission 2/17-3/8, 1991	3	2	1	15	Economist	Comp. I problems remain. Several policies required for effective project implementation delayed since Dec. 1990. PIU head is perceived too junior. Comp. II is on track.
Spn. Mission 5/29-6/8, 1991	3	2	1	10	Economist	Comp. I & II progress at slow pace. The mission and the planning department develop proposal for restructuring the PIU: move it under the CMO and increase staff.
Mission 09/29-10/04 1991	3	2	4	5	Public health specialist, economist, manpower specialist	Lack of progress in meeting legal covenants. Mission agreed not to recommend suspension of reimbursements to allow the new PIU more time to correct problems.
Spn. Mission 1/25-2/03, 1992 (workshop)	-	-	1	8	Public health specialists	Mission supports district health planning through a workshop in Singida. Several donors participate, but workshop does not produce expected outcomes. Different planning methods introduced; participants left without a clear notion of how to choose.

This table continues next page.

Table 12B Bank Missions (Continued)

Stage of Project Cycle	Imple-ment'n Status	Dev't Impact	No. Per-sons	Person-days	Skills Represented	Observations
Spn. Mission 6/22-7/7, 1992	3	2	2	16	Public health specialist, economist	PIU remains weak. New MOH leadership; policy changes initiated: revised PHC strategy, cost sharing, information system, and pharmaceuticals masterplan. Challenge is to implement changes in a coordinated fashion. Comp. II rated well.
Spn. Mission 9/14-9/26, 1992	3	2	2	13	N.A.	Little implementation progress. MOH proposes reallocation of credit. MOH/MORALG agree to procure TA to undertake studies required, and to strengthen PIU.
Spn. Mission 2/1-2/18, 1993	3	3	4	18	Economists, nutritionist, accountant, Young Professional	PIU is the major bottleneck. Mission recommends development of basic office procedures, annual business plans, and budgets and to use contractors to complete studies.
Spn. Mission 6/21-7/7, 1993	3	3	4	17	Health specialist, social sector specialist, family planning specialist, data management specialist	Despite agreements in previous mission, consultant to assist PIU and PSN not hired. Budget and annual plans not developed.
Spn. Mission 9/21-9/27, 1993	3	3	4	6	Economist, financial management specialist, health specialist	Management problems start to be resolved; focus shifts to technical problems including slow progress in Comp. I and low support for Comp. II and III. Comp. II seen as being too rehabilitation-oriented. In pharmaceuticals, GOT resists eliminating the public monopoly.
Spn. Mission 3/1-3/8, 1994	2	2	2	8	Economist, health specialist	Project performance increase tremendously, with consequent good ratings for most categories. Project management capability being enhanced. The challenge is in the organization of technical inputs.

This table continues next page.

Table 12B Bank Missions (Continued)

Stage of Project Cycle	Imple-ment'n Status	Dev't Impact	No. Per -sons	Person-days	Skills Represented	Observations
Midterm Review Mission 9/19-10/6, 1994	2	2	5	12	Social sector specialist, economists	Project management problems largely resolved but project still focusing too much on rehabilitation and provision of physical inputs instead of structural reforms to increase efficiency. The cost sharing program and some reforms in the pharmaceutical sector are the exceptions.
Spn. Mission 5/28-6/10, 1995	2	2	3	15	Economist, operations specialist, WB intern	Improving management should allow project to focus on technical side to improve delivery of services.
Spn. Mission 10/12-10/19, 1995	2	2	2	10	Economist, public health specialist	Project being implemented satisfactorily. All major construction works underway.
Spn. Mission 3/28-4/3, 1996	3	2	5	7	Economist, social sector specialist, project implementation assistant, accountant	All non-pharmaceutical procurements are at near contract stage. However, financial planning continues to be a problem. Rehabilitation of 10 district hospitals not likely to be completed by June 30, 1997 as planned.
Spn. Mission 4/15-4/26, 1996	3	2	5	11	Economist, social sector specialist, project implementation assistant, accountant	Mission decides to extend the project by two years to allow the CHF and other financing schemes to kick off and provide initial results before developing a new project.
Spn. Mission 7/25-8/16, 1996	3	2	4	20	Economist, social sector specialist, project assistant, accountant	Financial management has improved, but counterpart funds and cumbersome banking procedures continues to cause delays.
Spn. Mission 2/3-2/21, 1997	3	2	11	16.18	Health economist, financial specialist, operations officer, pharma. specialist, architect, accountant.	Major procurements are under implementation. However, counterpart funds remain a problem. Delays in rehabilitation of MSD. Erratic GOT funding for pharmaceuticals. A Hospital Drug Revolving Fund is proposed. HMIS and National Population Policy subcomponents remain problematic.

This table continues next page.

Table 12B Bank Missions (Continued)

Stage of Project Cycle	Imple-ment'n Status	Dev't Impact	No. Per -sons	Person-days	Skills Represented	Observations
Spn. Mission 6/11-7/11, 1997	2	2	7	16.43	National Health Accounts advisor, operations support assistant, financial management specialist, pharmaceutical specialist	Counterpart funds remain problematic. Hospital drug capitalization is a challenge given limited management and technical capacity in-country. Low salaries of public servants and abundant donor financing may be encouraging "rent-seeking" activities. Project has improved implementation but evaluation is needed especially of impact.
Spn. Mission 1/12-1/30, 1998	2	2	4	17	Operations specialist, health economist, financial management specialist	Counterpart funds have not been a problem in the FY. Progress in HMIS and cost sharing . GOT proposes a 12 months extension to utilize credit balance from savings for reform-related activities.
Spn. Mission 8/17-9/4, 1998	2	2	7	17.86	Sr. public health specialist, economist, health economist, operations specialist, financial management specialist	Implementation is satisfactory. Credit was extended from April 1998 to June 1999. Study of cost-sharing in 7 hospitals shows that 25-60% of revenue is not collected. Evaluation of the impacts of the CHF on the poor is required.
Last Spn. Mission 3/15-3/25, 1999	2	2	3	15	Sr. public health specialist, economist, health economist	Most activities on track. Project used as launch-pad for new credit.
ICR Mission 9/6-9/10, 1999 (ICR workshop)	2	2	2	10	Health economist, health specialist	Overall project is rated satisfactory. However, evaluation have focused on implementation and little is known about project impacts on the health status of the population.
Overall for supervision period	2	2	3.7 persons per spn mission	12.8 person-days per spn mission		

Key for ratings: 4=highly unsatisfactory; 3=unsatisfactory; 2=satisfactory; 1=highly satisfactory

APPENDIX A – COMPLETION MISSION'S AIDE MEMOIRE

ICR Mission for the Health and Nutrition Project
(Cr. 20980)

1. A World Bank team consisting of Emmanuel Malangalila (AFTMZ), Barney Laseko (AFTMZ), and Oscar Picazo (AFTH1) worked with Tanzania's Ministry of Health (MOH) between September 6 and 10, 1999 to assist the MOH prepare for its contribution towards the formulation of the Implementation Completion Report (ICR) of the Health and Nutrition (H&N) Project which was closed on June 30, 1999. The team wishes to acknowledge the excellent cooperation provided by the MOH and the Ministry of Regional Administration and Local Government (MRALG) for this ICR mission.

2. The mission noted that MOH has completed most of the statistical tables required to be annexed to the ICR including the project timetable; the inventory of studies, training, workshops/seminars, and study tours funded under the project; and the status of legal covenants. Bank resident mission staff are completing the financial tables (project financing, project costs and expenditures by category and by component) and these are expected to be completed shortly. Bank HQ staff will complete the tables pertaining to Bank staff inputs; the listing of all the missions undertaken during project identification, appraisal, and supervision; and the table on compliance with operational manual statements.

3. In conjunction with the field visit for the appraisal of the new Tanzania Health Sector Support Project, the ICR mission also visited the H&N Project-supported PHC Institute (one of the five government zonal training centers in Tanzania) and the Medical Supplies Department zonal store, both in Iringa Municipality. These two facilities are now providing the required training and medical supply services to their respective catchment areas. The mission's visit to the Isimani health center and to the Iringa Regional Hospital confirmed that indeed drugs are available, but this may be a function of the financing mechanism that have been put in place in these two facilities. The Isimani health center has established a Community Health Fund, which has allowed the facility to have supplemental drugs in addition to the monthly drug kit. On the other hand, the Iringa Regional Hospital has established a Drug Revolving Fund under the hospital drug capitalization program. Some MOH officers, however, noted that facilities without financing mechanisms still suffer from infrequent drug supplies.

4. The mission also met with the project coordinator of the recently-ended Dar Es Salaam Urban Health Project, funded by the Swiss Development Corporation, which was conceived as Component 3 of the H&N Project and was implemented as parallel-financing. The project was implemented in three phases in three urban districts between 1991 and 1999, and activities are being integrated into the regular work of the Dar Es Salaam City Council. Evaluation of Phases I and II of the project have been completed. From all indications, this Component appears to have been very successful in rehabilitating and supplying health facilities, motivating health workers, introducing cost sharing and Bamako Initiatives, and pioneering the implementation of Local Government

Reform through the establishment of facility health boards and district health boards, which were approved by both MOH and MRALG. Key lessons learned under this Component will be documented and annexed to the ICR.

5. From September 6-7, 1999 the World Bank team participated in the two-day ICR workshop organized by the MOH and the MRALG and held at the NIC Training Center in Mikocheni which brought together 47 program managers and staff involved in implementing the various components and sub-components of the H&N Project. During the ICR workshop, the mission explained the objectives of the ICR and the content of the report, the required inputs for the completion of the report, the schedule for the completion of these inputs, and the respective responsibilities of the MOH and project implementing agencies as well as IDA staff. The ICR workshop provided an internal MOH/MRALG assessment of the achievement of project objectives, achievement of component outcomes, the sustainability of project-supported activities and initiatives, Bank and Borrower performance under the project, and lessons learned under the project (which are also being applied in the subsequent IDA operation). GOT will produce the proceedings of this workshop and submit it to IDA as input into the ICR.

6. Participants to the GOT internal assessment workshop provided the following ratings:

(a) For Borrower/GOT performance: *deficient* for project preparation, *satisfactory* for project implementation, *satisfactory* for project covenant compliance, and *satisfactory* for operation. For Bank performance: *satisfactory* for project identification, *deficient* for project preparation, *deficient* for project appraisal, and *satisfactory* for project supervision. The explanations for these ratings are detailed in the workshop proceedings being prepared by the MOH. The participants also noted that the H&N Project was the first project engaged in by both the GOT and the Bank in Tanzania and that the project was identified, prepared and negotiated under very difficult circumstances (fiscal and foreign exchange crisis; scanty information on the sector; and evolving policy regime from free/government provision of health services to one that involves 'cost sharing' and privatization.)

(b) Overall, the project was rated 'satisfactory' and project outcome 'substantial' for most project components, except for the latter period (1996-98) of the population policy and planning subcomponent which was deemed of 'negligible' outcome. Most project activities were rated 'likely' to be sustainable, especially those relating to health financing, health planning and policy, MSD and pharmaceutical reforms, and health information system. Activities rated of 'uncertain' sustainability include the human resource development plan, maintenance for civil works, and community mobilization under the rural PHC subcomponent.

7. Based on the available documentation reviewed and discussions held with GOT officers and staff involved in the project, the IDA mission concurs in general with the GOT assessment on Bank and Borrower performance, as well as the overall project rating of 'satisfactory'. The mission also agrees with most of the GOT's outcome ratings and likelihood of sustainability of specific components and subcomponents of the project. IDA will conduct a more careful review of the project's internal documents to validate these ratings.

8. In addition to the MOH internal assessment, an external evaluation of the project is slated to be conducted in October 1999 to support the ICR process. This activity will be funded under the Project Preparation Facility (PPF). The MOH informed the mission that an independent consulting firm will conduct the evaluation. The mission underscored the very tight schedule of completing this activity, and the critical necessity of getting the results and findings from this evaluation as soon as possible as these will be used in the ICR. The external evaluation will provide independent assessment of the project in addition to other assessments that are available, e.g.:

- Program-specific evaluation of Component 1 activities, i.e., Cost Sharing Program and Community Health Fund pretests. The mission also noted MOH plan to conduct an evaluation of the Hospital Drug Capitalization Program.
- Internal evaluation of Component 2.
- Evaluation of Phases I and II of Component 3.
- OED evaluation of the pharmaceutical sector.
- DANIDA assessment of the Medical Stores Department and the pharmaceutical sector in general.
- Quality Assurance Group (QAG) report on the H&N Project.

Next Steps - The following are the agreed next steps between GOT and the IDA mission:

Action	Responsibility	By When
Completion and submission of the proceedings of the ICR workshop to IDA	MOH	Sept. 17, 1999
Completion of all required ICR tables to be annexed	MOH and IDA	Sept. 24, 1999
External evaluation of the project • Opening of financial bids • Evaluation of combined financial and technical bids • MOH submission of contractors' bids for IDA no-objection • IDA response to no-objection request • Notification of winning contractor • Contract negotiation • Start of contractor work • First draft of external evaluation report • GOT comments • Final external evaluation report	To be supervised by MOH	 Sept. 15, 1999 Sept. 22, 1999 Sept. 24, 1999 Sept. 30, 1999 Oct. 1, 1999 Oct. 8, 1999 Oct. 15, 1999 Nov. 15, 1999 Nov. 19, 1999 Nov. 26, 1999
Completion of first draft of ICR and distribution to Tanzania Country Team	IDA	Nov. 10, 1999
Tanzania Country Team review of ICR draft	IDA	Nov. 22, 1999
Submission of ICR draft to GOT for review	Review by MOH, MRALG, other agencies	Nov. 26, 1999
Completion of final ICR incorporating GOT comments and final IDA review	IDA	Dec. 10, 1999
Printing and distribution of ICR	IDA	Dec. 15, 1999

APPENDIX B – PROCEEDINGS OF THE MOH AND MRALG INTERNAL ASSESSMENT WORKSHOP FOR THE H&N PROJECT

A. Introduction

1. This report summarizes the proceedings of the Internal Assessment Workshop jointly sponsored by the MOH and MRALG to assess the end-of-project status of the IDA-funded Health and Nutrition Project which closed on June 30, 1999. The workshop was organized in time for the IDA mission for the preparation of the Implementation Completion Report (ICR) of the project. The workshop was held from September 6-7, 1999 at the NIC Training Center in Mikocheni area, Dar es Salaam and was attended by 40 participants (see list below) from both ministries who were involved in the project, representatives from the districts, selected consultants, and IDA staff who acted as facilitators. The objectives of the workshop were to assess the achievement of project objectives; prospects for the sustainability of project activities; Bank and Borrower performance of their respective obligations under the credit agreement; and Government's plan for the project's future operation.

2. The project had 3 components managed separately by different agencies: Component I dealing largely on policy and institutional development in health under MOH; Component II dealing on rural PHC under MRALG; and Component III dealing on urban PHC in Dar es Salaam, which was managed by the City Council with parallel financing from the Swiss Agency for Development and Cooperation (SDC). The H&N Project was the first that IDA financed in Tanzania's health sector. During the 9 years that the project was implemented, it saw 5 World Bank task managers, 7 MOH PS's and 2 MRALG PS's, 3 MOH project coordinators for Component I, and 2 MRALG project coordinators for Component II. There was no logframe when the project was designed but it underwent a logframe "retrofitting" exercise in 1997, which sequenced the various project activities in a logical manner indicating goals and objectives, measurable indicators, means of verification, and assumptions and risks.

3. In the group sessions, participants were organized into 7 groups according to project subcomponents as follows: (a) Control and Prevention of Micronutrient Deficiency + Implementation of Population Policy; (b) Health Manpower Planning + Health Planning and Policy Formulation; (c) Health Financing; (d) Drug Procurement and Pharmaceutical Sector Reforms + Health Management Information System; (e) Strengthening of Rural/District Primary Health Care; (f) Civil Works; and (g) Project Management. Each group was assigned a common set of questions. The groups were provided with the project logical framework, statistical information on project accomplishments, and other data as source documents. On the second day, workshop participants assessed the project objectives and Bank and Borrower performance under the project. Participants were organized at random into 4 groups which were assigned a common set of questions.

4. Overall, workshop participants gave a *satisfactory* rating for the project. The unsatisfactory status of the project in its first three years led to a project redesign that dramatically improved performance to satisfactory level throughout most of its middle

years, and highly satisfactory in the last couple of years. Supporting this rating were the following observations: (a) Subcomponent implementors were clear of the project development objectives and all worked hard to achieve them. (b) Annual workplans facilitated coordination of the many subcomponents of the complex project. (c) Project achievements were either substantial or satisfactory because the support system and technical assistance provided by IDA in the areas of disbursements, supervision, and the conduct of operational and technical studies. (d) Substantial capacity building for implementation was provided in the form of on-the-job training, formal training and logistical support (vehicles, equipment, communication, etc.) (e) Sustainability of the H&N Project is likely in terms of human resources, considering the number of people trained under the project. (f) Project achievement was a result of substantial government commitment to the project. However, the project had too many conditionalities which affected the pace of implementation especially in the first three years.

B. Achievement of Project Development Objectives

5. Achievement of project objectives were rated by groups as substantial, partial, or negligible in terms of the various objectives as shown in Table B-1. Overall, the groups rated the project's meeting its development objectives as *substantial.*

Table B-1: Achievement of Project Objectives

Objectives	Group 1	Group 2	Group 3	Group 4	Plenary
Macro policies	Substantial	Substantial	Substantial	Substantial	Substantial
Health sector policies	Substantial	Substantial	Substantial	Substantial	Substantial
Financial objectives	Substantial	Partial	Substantial	Substantial	Substantial
Institutional dev't	Partial	Substantial	Substantial	Substantial	Substantial
Physical objectives	Substantial	Substantial	Substantial	Substantial	Substantial
Poverty reduction	Partial	Partial	Not applic.	Partial	Partial
Gender issues	Partial	Partial	Not applic.	Not applic.	Partial
Other social obj.	Negligible	Substantial	Partial	Negligible	Partial
Environmental obj.	Substantial	Partial	Substantial	Not applic.	Partial
Public sector mgt.	Partial	Partial	Substantial	Substantial	Partial
Private sector dev't	Not applic.	Not applic.	Not applic.	Substantial	Not applic.

Note: There was no plenary agreement on what should be rated 'partial' or 'not applicable'. In certain cases, 'partial' meant that the objective under consideration was not central to or a direct concern of the project, or alternatively that the project only achieved its targets partially under that objective. In other cases, if that objective was not central to or a direct concern of the project, then it was rated 'not applicable'. In any case, the above table summarizes what was reported during the plenary discussion, but caution should be exercised in the interpretation of these two ratings which were often used interchangeably.

Source: Internal Assessment Workshop, Day 2

- Macro policies - Government health expenditures substantially increased from 6% in the 1980s to 12% in 1997/98. Various alternative health financing options have been developed, tested and implemented (e.g., CSP, CHF, NHI).
- Sector policies – Key sector policies were developed under the project, e.g., fee policy at government facilities, HMIS, pharmaceutical sector reform, and Human Resource for Health Development.
- Financial objectives – Substantial achievements were achieved in financial resource mobilization through CSP, CHF, and drug capitalization, thus reducing the financing gap in the sector. Funds have been mobilized from various sources, e.g., donor funds, countepart funds, and community contributions through user fees, prepayments, and in-kind. However, in some cases, there were some delays in GOT provision of counterpart funds.
- Institutional development – District health planning were introduced in the 10 districts under the project. DHMTs and DHBs have been established in the focus districts. However, DHMTs are yet to fully manage PHC programs under their jurisdictions. The MSD has been made autonomous.
- Physical objectives – Substantial achievements were achieved in the rehabilitation of health facilities, e.g., MSD central office and zonal stores; zonal training centers; and district hospitals, health centers and dispensaries in the 10 districts. However, the rehabilitation plan did not cover all the requirements, e.g., incinerators at health centers and dispensaries. Acquisition of medical equipment, drugs, and supplies was effected as planned, except in the case of Tender #7.
- Poverty reduction – There were no direct verifiable indicators on poverty set during project design, although improvement of health status contributes to poverty reduction.
- Gender issues – There were no direct verifiable indicators on gender set during project design; the project was targeted at the entire population especially in the focus districts.
- Other social objectives – During project implementation, social cohesion was promoted in focus districts through CHFs, day-care centers, and shallow well construction.
- Environmental objectives – These were not specified in the project. However, incinerators were built in the 10 district hospitals.
- Public sector management - Examples include the autonomization of MSD, the establishment of DHBs in the focus districts, and the implementation of district health plans.
- Private sector development – These were not specified in the project but certain financing schemes (CHF, health insurance) promotes private sector financing.

C. Achievement of Component Outcomes and Sustainability

6. Project outcome was rated *substantial* for Micronutrients, Health Planning and Policy, Human Resource Development, Pharmaceutical Sector Reforms, Health Financing, and Civil Works (Table B-2). Achievements were less dramatic for Health Information System, and *negligible* for the latter years of Population Policy and Planning.

Table B-2: Assessment of Outcome and Sustainability of Project Subcomponents

Subcomponents	Rated Outcome	Likelihood of Sustainability
Control and Prevention of Micronutrient Deficiency	Substantial	Likely
Implementation of Population Policy	Mixed	Note Rated
Health Planning and Policy Formulation	Substantial	Likely
Health Manpower Planning and Policy and Human Resource Development		
Health Manpower Planning and Policy	Substantial	Likely
Human Resource Development	Substantial	Uncertain
Health Information System	Not Rated	Likely
Health Financing	Substantial	Likely
Drug Procurement and Pharmaceutical Sector Reforms	Substantial	Likely
Strengthening Rural Primary Health Care		
Rural PHC	Substantial	Mixed
District PHC	Substantial	Mixed
Civil Works	Substantial	Uncertain
Project Management	Substantial	Likely

Source: Internal Assessment Workshop, Day 1

7. Micronutrient Deficiency Control: Speed of implementation in this subcomponent was due largely to the autonomy of the implementing institution that reduced bureaucratic obstacles and provided sound financial management. The subcomponent has established a micronutrient surveillance system, but monitoring and evaluation need to be strengthened.

8. Health Policy and Planning + Human Resources Development: Financial sustainability is uncertain since the department depends on the Government budget to implement the activities including the Five Years Plan. Although the project did train staff for the DHO and zonal centers, still the capacity is low in terms of quality. District training is likely to be sustained because the districts will have funds under decentralization and will be trained at the zonal centers and elsewhere. Study on long-term financing of the health sector has been completed through a combination of various studies on Cost-sharing, Health insurance, CHF, Drug revolving Fund, etc. Challenge is how to retain and sustain the capacity already built in the Planning Department.

9. MSD and HMIS: Sustainability of HMIS as any other management information system is dependant on the level of financing. Block grants to districts pose uncertainity for districts to purchase drugs from MSD, What incentives could MSD provide to get districts buy drugs from them? May be distribution of drugs to districts by MSD could be

an incentive. Patient waiver and exemptions pose uncertainties for sustainability of the drug revolving fund.

10. Health Financing: Has reduced the financing gap in the health sector. Has increased community awareness and participation in financing and management for health. Has contributed decentralizing decision making in the health sector. Has met community expectations for drugs. Has proven community willingness to pay provided the system is transparent. The matching element is unlikely to be sustained without government/donor support. There is over-expectation of benefit package and hence tendency of over-utilization of services. Matching is not necessarily a motivation but people are interested in the quality of services rendered.

11. Rural PHC: Most of the project support was on the rehabilitation of infrastructures and PHC interventions. There is pronounced community participation for rehabilitation, but rehabilitated health facilities need to be strengthened with relevant staff, equipment and drugs. Very specialized equipment should be acquired by selective tendering rather than ICB to avoid getting substandard equipment.

12. Civil Works: The project was not meant to put up new structures but in the process of rehabilitation, it involved also putting up new structures in case of technical necessity. Maintenance of the rehabilitated facilities will be achieved if funds will be allocated for this purpose. Pronounced community participation experienced. The estimate for rehabilitation of a dispensary was Tsh 10 million, for health centers was Tshs 38 million and for the hospitals was Tshs 250 million. The quality of the rehabilitation which also includes the community participation of the local community was satisfactory.

13. Project Management: The project started slowly because of difficulty experienced by project staff regarding World Bank procurement procedures. Frequent changes of managers (Task Managers, Project Coordinators, and Permanent Secretaries) contributed to implementation delay. In 1994/95 and 1995/96 there was inadequate counterpart funding which lead to problems in implementation of the project (which led to the suggestion to integrate this capacity into SWAp). There is a need for the MOH and the MRALG to utilize the capacity which has been built during the implementation of the project in the future project/programs.

D. Assessment of Bank Performance

14. Workshop participants rated Bank performance as satisfactory for project identification, deficient for preparation, deficient for appraisal, and satisfactory for supervision (Table B-3). This was the first IDA project in Tanzania's health sector; as such it had very little experience in the country to go by. On hindsight, it also appears that the IDA project identification team was unable to use IDA experiences in other countries to advise GOT of good practices. Stakeholder consultations were scanty, and IDA placed too many covenants and conditionalities on the project. Implementation was extremely difficult and supervision was unsatisfactory for the project's first three years. Frequent changes of task manager may also have contributed to delays in decision making. As the project progressed, supervision improved and by the last two years of the

project, supervision was being rated highly satisfactory, with IDA providing sufficient technical assistance for these latter years.

Table B-3: Assessment of Bank Performance

Project Stage	Group 1	Group 2	Group 3	Group 4	Plenary
Identification	Deficient	Not rated	Deficient	Highly satisfactory	Satisfactory
Preparation	Deficient	Deficient	Not rated	Satisfactory	Deficient
Appraisal	Deficient	Not rated	Not rated	Satisfactory	Deficient
Supervision	Satisfactory	Satisfactory	Satisfactory	Highly satisfactory	Satisfactory

Note: In some cases, groups declined to provide ratings due to their lack of institutional memory on what transpired during the early years of the project, or their inability to reach a consensus within the group of a quantitative rating.

Source: Internal Assessment Workshop, Day 2

E. Assessment of Borrower Performance

15. Workshop participants rated Borrower performance as deficient for preparation, satisfactory for implementation, satisfactory for covenant compliance, and satisfactory for operation (Table B-4). Being the first IDA credit in the sector, GOT took some time to learn how to implement such a project. Too many covenants put forward by IDA were accepted by GOT without a thorough understanding of their implications. Frequent changes of Permanent Secretaries and Project Coordinators in the two implementing Ministries contributed to delays in decision making.

Table B-4: Assessment of Borrower Performance

Project Stage	Group 1	Group 2	Group 3	Group 4	Plenary
Preparation	Deficient	Not rated	Not rated	Highly Satisfactory	Deficient
Implementation	Satisfactory	Satisfactory	Not rated	Satisfactory	Satisfactory
Covenant compliance	Satisfactory	Satisfactory	Not rated	Satisfactory	Satisfactory
Operation	Satisfactory	Satisfactory	Not rated	Highly satisfactory	Satisfactory

Note: In some cases, groups declined to provide ratings due to their lack of institutional memory on what transpired during the early years of the project, or their inability to reach a consensus within the group of a quantitative rating.

Source: Internal Assessment Workshop, Day 2

16. Despite initial difficulties, GOT commitment to the project and to the sector in general lead to successful implementation of project activities. GOT succeeded in mobilizing and sensitizing communities to participate in the implementation of specific subcomponents, e.g. contribution of available local materials in facility rehabilitation, community contributions in CHF, which created awareness and ownership. Multisectoral involvement was also a key ingredient of successful project implementation, especially in the latter years. Manpower development and capacity building was achieved during the project implementation. GOT fulfilled all project covenants. There were delays in the fulfillment of covenants in the early years since reasonable time was needed to familiarize with IDA conditionalities. Generally, project operations were undertaken satisfactorily. However, there is a need for addressing further to the sustainable measures in order to arrive at the intended objective.

F. Lessons Learned

17. The key lessons learned form this project are as follows: (a) Frequent changes in project management as well as IDA task management jeopardizes smooth implementation. (b) Mutual understanding between partners is a prerequisite for success in project implementation. (c) Timely availability of resources facilitates the implementation of planned activities. (d) Major reforms to effect and sustain policy changes require political, legal, and administrative backing. (e) For successful project implementation, conditionalities should be reduced to the barest minimum. (f) In the design of any prepayment scheme, it is important to consider members' willingness and ability to pay. (g) Issues of equity and modalities of reimbursing health facilities for the foregone income from the granting of waivers and exemption should be addressed. (h) Community participation is crucial to ensure the sustainability of both prepayment schemes and rehabilitation programs. (i) ICB is not necessarily the optimum procurement method for specialized hospital instruments and equipment, especially for a country like Tanzania with limited pre-shipment and post-shipment inspection capability. One ICB resulted in the procurement of substandard goods which, on hindsight, could have been avoided if the experience and advise of the Ministry Tender Board in favor of selective tendering procedures were considered. (j) Operating through L/C can be more expensive and laborious than effecting direct payment against shipping documents. (k) With good choice of local contractors at national level, quality results for rehabilitation can be achieved.

Table B-5: List of Participants to the MOH and MORALG Internal Assessment Workshop

Name	Title	Institution
W.B. Bategeki	PPO	TFNC
S.K.M. Bituro	Health Insurance Specialist	MOH/HIIT
H.M. Gondwe	Local Government Commissioner	MORALG

A. Hingora	Head, PHC Secretariat	MOH
Peter A. Ilomo	Economist, CSP	MOH
Y.A. Ipuge	HDS	MOH
S.B. Kahitwa	Project Coordinator, Component II	MORALG/PSN
J.T. Kahwa	Project Engineer	MRALG/PSN
Adolph Kapinga	Senior Researcher	Muhimbili University College of Health Sciences
S.L. Kibaja	Sr. Financial Mgt. Officer	MOF
Regina L. Kikuli	Head, Budget Section	MOH
S. Kimboka	Department Director	TFNC
Agnes Kinemo	Training Officer	MOH
Barney Laseko	Portfolio Mgt. Specialist	World Bank
Mussa A. Lupatu	Managing Director	Merit International, Ltd.
Emmanuel Malangalila	Public Health Specialist	World Bank
M.K.K. Mapunda	Senior Economist	MOH/HIIT
R.M. Marealle	Engineer	MOH
Gradeline Minja	Health Economist	MOH/HIIT
E.M. Mjema	Senior Statistician	Planning Commission
A.H. Mkini	Executive Secretary	MOH
K.A. Mmuni	Consultant, CHF	MOH/CHF
Christopher Msemo	Director of Procurement	MOH
J.O. Mtalo	Architect	MOH
Magessa Mugusi	Coordinator, DRF	MOH/DRF
J. Mutayoba	Health Secretary	MOH
S.E.L. Ndandala	PPO-PPT	MOH
B.T. Ndawi	Director, Primary Health Care Institute	MOH
M. Ndomondo	Registrar, Pharmacy Board	MOH
S.E. Ngatunga	Head, Health Management Information System	MOH
F.N. Njau	Project Coordinator, Component I	MOH/PIU
M. Nyantahe	Accountant	MOH
Abdallah Omar	Statistician	Planning Commission
Oscar F. Picazo	Health Economist	World Bank
J.K. Senge	Project Manager	MRALG/PSN
D. Simba	TTO-HMIS	MOH
Rogatian M. Shirima	Coordinator, CHF	MOH/CHF
I.G. Voniatis	Accountant	MOH
A.K. Wantiko	Project Accountant	MRALG/PSN

Key: TFNC=Tanzania Food and Nutrition Council; PSN=Project Support Network

APPENDIX C – BORROWER'S COMMENTS ON THE ICR

THE UNITED REPUBLIC OF TANZANIA
MINISTRY OF HEALTH

Telegrams: "AFYA", DAR ES SALAAM
Telephone: 20261
(All letters should be addressed to
the Principal Secretary)
In reply please quote:

P.O. Box 9083,
DAR ES SALAAM

Ref. No. HEU/20/11/Vol.II/60 **14 December 1999**

Chiyo Kanda,
Economist,
Human Development Group I,
Africa Region.

COMMENTS ON THE DRAFT ICR IDA Cr. 2098-TA

We are in receipt of the above draft ICR report and having gone through the contents, the government would like to submit the following comments.

1. The report reflects a true picture of the evolution of the H&NP, its problems from inception to the date of credit closure. The chronology of events and lessons learned gives us enough focus and experience of undertaking similar arrangements with the World Bank. However, we would like to rectify some of the few factual errors reflected in the report; Paragraph 4; the performance of Population Policy Unit should not be assessed within the health and Nutriton Project resources only. If it is looked in the context of other resources the unit managed to develop the population policy and implement some of the activities of the policy in the Family Planning programme. Paragraph 25:The current Health and Nutrition Project co-ordinator for component I is the third co-ordinator and not the fifth. Table 7A: Development of fee structure and alternative provider payment scheme for NHI Program was undertaken in June 1999.

2. Apart from these corrections we would like to raise the following comments. Table 10 on STATUS OF LEGAL COVENANTS span from page XXX to page XXXVI - six pages of appendix A of the Aide memoire these array of conditionalities would have surprised any body and scare off the implementors. Why so many covenants, and whether they were at all useful is subject for evaluation. These covenants at best helped to create the mistrust and suspicion which lingered on during the first years of project implementation. It would be wise to avoid such blocking conditionalities in the next programme.

3. We take note that this draft ICR is completed before the Project is Externally Evaluated, thus it misses an important input which would have otherwise been obtained if the Evaluation was completed first.

4. Para 26 of Appendix A pg. Vii, on Procurement: Specifically on Tender No. 7 of 1997/98 - Medical Instruments, it is not true that capacity to procure was not there. The problem lies with the rigidity of IDA adherence to the procurement Guidelines which appear to be "cast on Stone"

5. The procurement team in understanding the speciality of these instruments, their importance for the delivery of Health care to patients, asked IDA to approach the procurement through shortlisting of well known manufacturers of these instruments and sophisticated equipment but IDA refused. During the process, the winning bidder offered exceptionally low prices for these equipment (the prices were obviously an outlier in any known normal distribution curve). Once again the IDA was informed of this anomaly and the wish of the Tender Board to award the contract to the one with more reasonable pricing indicators.

6. This move was as it was once again blocked by IDA. These anomalies question the robustness of the World Bank procurement guidelines and their universal application regardless. Pre shipment and post shipment inspections, however strong will not be able to resolve these discrepancies as is being suggested. **There is a need** for the procurement process of medical instruments and technical equipment to prequalify or short list the suppliers. The World Bank guidelines appear to have an objective to ensuring fairness to the suppliers to the expense of purchasers objective of quality goods and value for money spent. It is reflected that procurement of technical assistance still leaves much to be desired, especially for quality and cost-based selection and is recommending that in the interm procurement should be through **a procurement Agent.** We note that statement generically appeared in the August/September Aide memoire for HSDP appraisal mission where procurement agent for the Ministry of Health was proposed but rejected. This is an ICR for the concluded Health and Nutrition Project IDA Cr. 2098 TA. where as it is reflected in Table 7A: STUDIES CONDUCTED UNDER THE PROJECT pg xxii most of the consultants were recruited through QCBS with a no objection from IDA we received Technical Assistance from IDA as required but the issue of the weakness on the QCBS was not raised then. The weakness in reference can only be applied to HSDP under PPF, where we have received different advices from the World Bank and with the anticipated time constraint of the closing of PPF, it would be next to impossible to pursue QCBS without being time barred. No comment were made on the procurement cycle tabled with the PPF plan. These discrepancies may not be sufficient reason of putting a procurement agent upfront, watering down the principle of on demand basis or pull system. A procurement Agent is an expensive affair and is not sustainable in absence of a donor to meet the costs. Under the ended Health and Nutrition Project, we used procurement agents on demand Hifab International for TFNC component and Comp.II, UNICEF for Drugs and IAPSO for office supplies and computers for Comp.I. The fees involved were exorbitant and unlikely to be sustainable. It is also in records that Hifab International failed as an agent to assist TFNC to procure oil processing Machine (a capacity issues as well) till TFNC solicited its own bids and handed the process by local staff. This reminds us that procurement agents are not a panacea solution to the all procurement issues.

7. Para 29 of Appendix A pg. IX on late completion of civil works! It was explained that late completion was due to poor accessibility to the project sites due to Elnino Rains which damaged the road infrastructure and not only the rehabilitation programme completion to be delayed but also all other activities in the area. This fact was crossed over to the mission during the ICR workshop.

8. Para 37 of the report Appendix A hazard that "Issues have been raised with respect to Local Government reforms Program. ..... block grants to purchase drugs for their facilities. ..... May authorize local authorities to purchase drugs elsewhere, creating uncertainty in MSD's present captive market". We all know that Drugs and Medical supplies are the most sensitive input items in the health care system. We also know the Local Government reform Programme has checks and balances and under HSRP - strategy 5 addresses issues of central support which include but not limited to drugs supplies and management system. There is a system in place for procurement to ensure qualify and potency of drugs.

9. If all 114 districts were to be left alone to buy drugs elsewhere, the exercise would be very expensive, and uneconomical as economies of scale will be lost. Secondly the quality of drugs from the elsewhere can not be assured.

10. On the issue of Drugs Revolving Fund and the 50% policy of recovery, it is too early to say "..... inhibits the development of fully refinancing mechanism", The RDF - Capitalization programme is subject to evaluation hopefully in January. It is until then we can make firm statements on the programme. The commitment of the government to increase its budgetary allocation to the Health Sector and other social sectors is known. We believe that one of the areas to allocate such funds is to offset the drugs deficit under RDF.

11. Para 40 pg Xii - This paragraph notes that, sustainability of the health system remains fragile and recommends serious stock-taking within GOT needs to occur on the optimal size of the health system that the country and its donors - partners can afford!! We thought the process of reforming the sectors, including MORALG, HSR, and the changing role of the Government including the Civil Service reforms are a direction towards that end. The per capita expenditure on the health service is less than US$7 including out of pocket spending (Private financing) The intention of the HSR agenda is to increase resource allocation in this sector. Since we have PoW/PoA/PAID and HSR - proposals, we need to work within this approved frame work if we wish to advise better methods of viewing the sector.

12. Para 44:- Having observed the fact that the work done on the 10 districts on rehabilitation barely scratched the surface, out of 114 districts, one would have expected a recommendation to have activities of rehabilitation in the HSDP forth coming incrementally to address the obvious problem. No where in this report, this recommendation is addressed.

13. The MRALG stresses on necessity for involvement and support of the Technical Coordination Team (TCT) at the Ministry level, to co-ordinate various activities such as setting out baseline data on rehabilitation and strengthening of health facilities needs from the respective districts.

14. Para 45 on financing, the schemes are said to have high start up costs and maintenance costs. Definitely the government would appreciate a recommendation on how to reduce the costs without affecting the establishment of the programmes. Secondly those who are concerned need to assist the programmes how to address the cost issues, by putting forward concrete suggestions and support.

15. Thank you for your well elaborated ICR which has very valuable observation and recommendations which we shall take seriously during the implementation of the next phase of our joint undertaking.

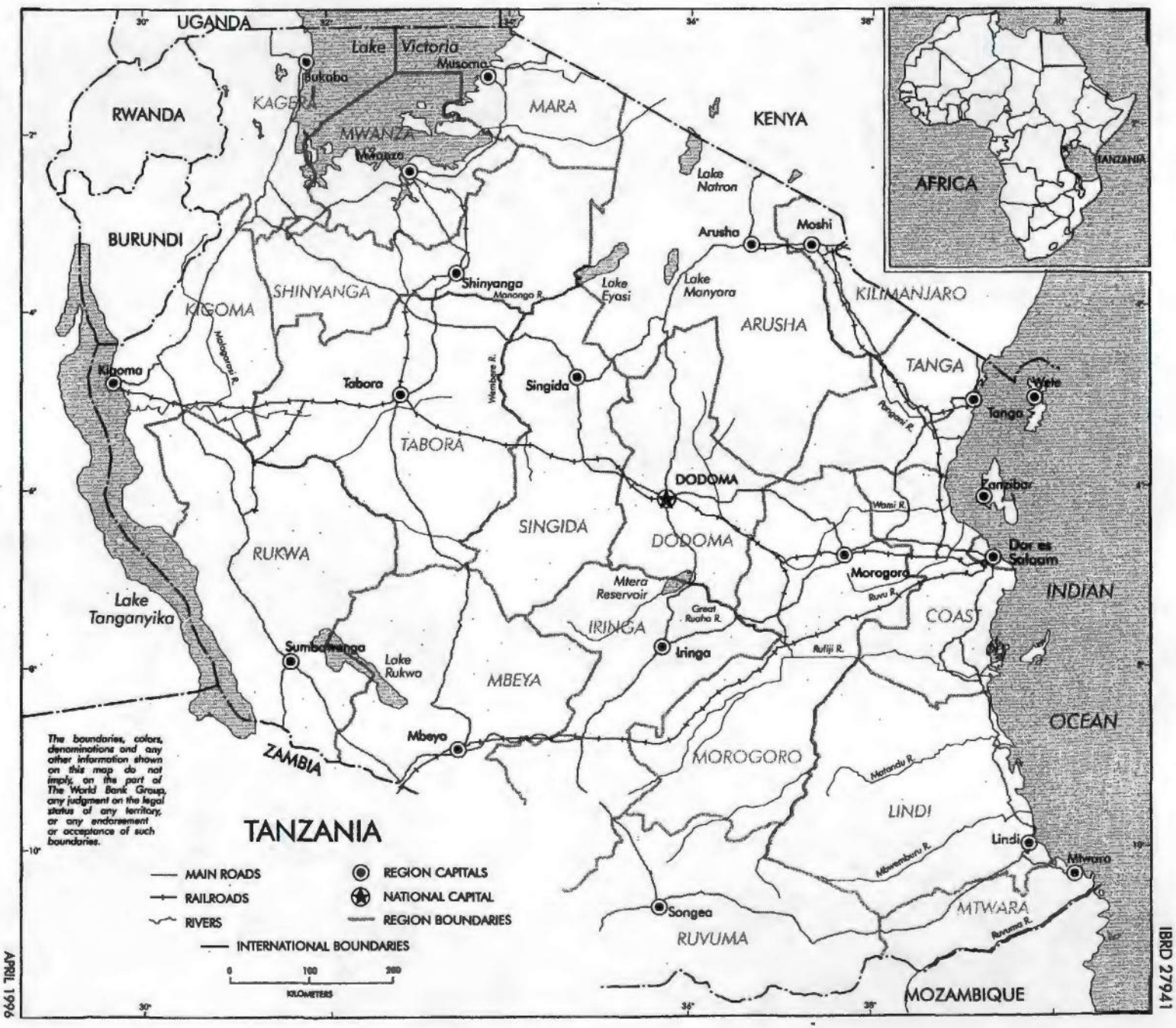
16. We have given our comments on the areas we felt were necessary to do so, and it is our sincere hope you will consider these comments in the finalization of this very important report and will be taken on board during the design phase of our next Health Sector Development Programme including the implementation phase.

I wish you Happy X-mass and New year.

Sincerely,

M.J. Mwaffisi
PERMANENT SECRETARY

APPENDIX D – OFFICIAL MAP OF TANZANIA


UGANDA
RWANDA
BURUNDI
KENYA
TANZANIA
AFRICA
Lake Victoria
Bukoba
Musoma
Mwanza
KAGERA
MWANZA
MARA
Lake Natron
Arusha
Moshi
Shinyanga
Manonga R.
Lake Eyasi
Lake Manyara
KILIMANJARO
ARUSHA
SHINYANGA
KIGOMA
Malagarasi R.
Kigoma
Tabora
Wembere R.
Singida
TANGA
Pangani R.
Wete
Tanga
TABORA
DODOMA
Zanzibar
Wami R.
SINGIDA
DODOMA
Dar es Salaam
Morogoro
Mtera Reservoir
Ruvu R.
INDIAN
COAST
RUKWA
Great Ruaha R.
IRINGA
Iringa
Rufiji R.
Lake Tanganyika
Sumbawanga
Lake Rukwa
MBEYA
OCEAN
Mbeya
ZAMBIA
MOROGORO
Mtandu R.
LINDI
Lindi
Mbwemburu R.
Mtwara
MTWARA
Songea
RUVUMA
Ruvuma R.
MOZAMBIQUE
TANZANIA
MAIN ROADS
RAILROADS
RIVERS
INTERNATIONAL BOUNDARIES
REGION CAPITALS
NATIONAL CAPITAL
REGION BOUNDARIES
0 100 200
KILOMETERS
The boundaries, colors, denominations and any other information shown on this map do not imply, on the part of The World Bank Group, any judgment on the legal status of any territory, or any endorsement or acceptance of such boundaries.
APRIL 1996
IBRD 27941

END

END

ICR Review - Evaluation Summary

Operations Evaluation Department

1. Project Data:		ES Date Posted: 05/01/2000		
PROJ ID: P002774 **OEDID:** C2098			**Appraisal**	**Actual**
Project Name: Health & Nutrition		**Project Costs (US$M)**	70	51.77
Country: Tanzania		**Loan/Credit (US$M)**	47.6	47.6
Sector, Major Sect.: Basic Health, Population Health & Nutrition		**Cofinancing (US$M)**	15	N.A.
L/C Number: C2098				
		Board Approval (FY)		90
Partners involved: Gov't of Belgium, ODA/DfID, Danida, UNFPA, SDC		**Closing Date**	06/30/96	06/30/99

Prepared by:	Reviewed by:	Group Manager:	Group:
Timothy A. Johnston	Roy Gilbert	Gregory K. Ingram	OEDST

2. Project Objectives and Components

a. Objectives

The project sought to raise the quality, coverage, and effectiveness of family planning, nutrition and basic health services through provision of support to critical and strategic elements of the HNP sector.

b. Components

Project components included: (i) institutional capacity strengthening for health planning and policy formation; (ii) manpower development and training in the health sector; (iii) sustainable provision and financing of pharmaceuticals and medical supplies; (iv) control of micronutrient deficiency; (v) implementation of the national population policy; (vi) enhance rural primary health care through a trial implementation of a revised PHC strategy; and (vii) strengthened urban primary health care in Dar es Salaam.

c. Comments on Project Cost, Financing and Dates

The project was approved in March 1990. The project closing date was extended twice, first in June 1996 to accommodate delays the first three years of project effectiveness, and the second in April 1998 to allow pretest alternative financing schemes and support preparation of broader sector reform initiatives.

3. Achievement of Relevant Objectives:

Most of the relevant objectives were achieved, although with significant delays.

(i) The *Strengthening National HNP Systems* component achieved most of its objectives. Project-sponsored TA and training strengthened planning and technical capacity at both district and national level. Project conditions contributed to several key policy reforms, including increased budget allocations to health (from 7 percent in the late 1980s to 12 percent in 1998/99); introduction of cost-sharing in government facilities; and autonomization of the Central Medical Stores. Pharmaceutical reforms and direct project support for drug procurement improved drug availability, particularly in districts with revolving drug funds. The Micronutrient Deficiency Control component appeared to have only mixed impact, however, and the National Population Policy component was unsuccessful.

(ii) *Strengthening Rural Primary Health Care*: This component had modest success in increasing community involvement, but participation focused on rehabilitating health facilities rather than nutritional activities. Facility rehabilitation and equipment have improved facility quality in rural clinics and district hospitals, but the impact on utilization was lower than expected.

(iii) *Dar Es Salaam Urban Health Project:* This component was fully satisfactory, and helped rehabilitate 60 urban facilities, establish local health boards, introduce cost-sharing, and establish a preventive maintenance program.

4. Significant Outcomes/Impacts:
The project eventually contributed to important sector reforms and policy changes, particularly for health financing and the pharmaceutical sector. The project supported autonomization, recapitalization, and managerial strengthening for the state Medical Stores Department, which has strengthened its financial viability and reduced stock-outs at the central level. To improve drug supplies at the end-user level, the project helped establish facility-level revolving drug funds in 23 districts (out of 114), and piloted Community Health Funds (CHF) in 10 districts. A 1999 survey found that drug availability had improved significantly in CHF facilities, compared to 1996. Project conditionality contributed to a doubling of the percentage budget allocation to the health sector. These measures should contribute to the financial sustainability of the sector. The project also contributed to improved basic infrastructure in Dar es Salaam and 10 of the poorest districts, and piloted an innovative maintenance scheme for urban health centers, which could be more widely replicated, particularly at district level. Training provided through the project has helped increase capacity at both central and district levels. The project help lay the groundwork for the current multi-donor Health Sector Reform Program, which should help alleviate the severe fragmentation that has characterized previous donor support to the Tanzania health sector.

5. Significant Shortcomings (including non-compliance with safeguard policies):
The project suffered from inadequate quality at entry, because of overly complex design involving multiple implementing ministries; inadequate ownership and stakeholder involvement; and poorly designed cross-conditionalities, which resulted in little disbursement for the first three years. A mid-term review in 1993 led to project restructuring in 1996, and subsequent improvements in Bank and borrower implementation performance. Shortages of counterpart funds further delayed implementation in the mid-1990s, but the situation improved following an improved macroeconomic situation in the late-1990s. Drug stock-outs remain a problem in districts or facilities that have not yet implemented revolving drug funds. Bank performance in initial project design and supervision was unsatisfactory, and supervision was disrupted by the transfer of the Tanzania portfolio from the southern Africa region to East Africa in the late 1980s.

6. Ratings:	ICR	OED Review	Reason for Disagreement/Comments
Outcome:	Satisfactory	Satisfactory	Substantial progress in final years compensates for unsatisfactory quality at entry.
Institutional Dev.:	Partial	Substantial	Progress on difficult pharmaceutical and financial reforms merit a rating of "substantial"
Sustainability:	Uncertain	Uncertain	Given Tanzania's heavy reliance on donor funds for sector financing, sustainability remains a challenge.
Bank Performance:	Satisfactory	Satisfactory	
Borrower Perf.:	Satisfactory	Satisfactory	
Quality of ICR:		Satisfactory	

7. Lessons of Broad Applicability:
Relevant lessons include:

- Complex policy reforms are better pursued as project outcomes rather than up-front conditionalities;
- The involvement of multiple agency/ministries must be weighed carefully -- the potential benefits can be undermined by the difficulties of intersectoral coordination;
- Project components should consist of closely-related activities; otherwise supervision becomes extremely difficult
- Macroeconomic analysis and policy work should be closely coordinated with sector dialogue, and can be mutually enhancing
- Baseline data and clear performance targets are essential for effective project supervision and impact evaluation

8. Audit Recommended? ○ Yes ● No

9. Comments on Quality of ICR:
ICR was well-written, but included little data on outcomes at the end-user level. Incorporation of findings from an independent impact evaluation conducted in early 2000 would have strengthened the ICR. The stakeholder ICR workshop (summarized in Appendix B) is a "good practice" example that could be more widely replicated.

This PIF was posted on May 1, 2000

OED ID :	C2098
Type :	ES
Country :	Tanzania
Project Description :	Health and Nutrition
Sector :	HX / Population, Health & Nutrition
Subsector :	HB / Basic Health
Lending Instrument :	Specific Investment
L/C :	C2098

Operations Evaluation Department
PROJECT INFORMATION FORM

Table of Contents

A1. General Project Information

OED ID :	C2098
Type :	ES
Country :	Tanzania
Project Description :	Health and Nutrition
Sector :	HX / Population, Health & Nutrition
Subsector :	HB / Basic Health
Lending Instrument :	Specific Investment
L/C :	C2098

1. Reviewer: Tim Johnston

2. Do you agree with the assigned primary Sector and Subsector? (●) Yes ( ) No

Sugg. Sector:
Sugg. Subsector:

3. Key Dates

	Original	Latest
Departure of Appraisal Mission		01/10/1989
Approval		03/06/1990
Signing/Agreement		03/07/1990
Effectiveness	06/07/1990	04/06/1990
Physical completion	12/31/1996	12/31/1999
Closing	06/30/1996	06/30/1999
ICR receipt in OED		12/30/1999
Review date		04/11/2000
ES posting or PAR approval		05/01/2000

4. Key Amounts ($US million)

Original Commitment	47.6
Total Cancellation	3.18
Total project cost	
Original	70
Latest	51.7

5. Cofinanciers

	First	Second	Third
Name	Swiss Development Corp.	Danida	UNFPA
Original Commitment ($US million)	12.2	1.3	0.7
Total Cancellation ($US million)	0	0	0

6. Distribution of latest cost among component types ($US million):

Physical	38.2
Technical assistance	13.1
Balance of payments	0
Line of credit	0
Other	0.4

7. Applicable disbursement profile (no. of years): 9

8. Number of supervision missions: 22

9. Name(s) of primary author(s) of ICR (indicate if not known): Oscar Picazo

10. Names of managers

	At entry	At exit
Task manager	John Innes	Chiyo Kanda
Division chief	David de Ferranti	Dzingai Mutumbike
Department director	Sven Sandstrom	James Adams

A2. Project Objectives Evaluation

1. Were the project objectives substantially revised during implementation? **Yes**

   If Yes, did the Board approve the revised objectives as part of a formal restructuring? **No**

   Date of Board approval

Note: If objectives were substantially revised, base the ratings in sections B1 and B2 on the revised objectives.

2. Taking into account the country's level of development and the competence of the implementing agency, to what extent did the project design have the following characteristics:

Demanding on Borrower / Implementing Agency	High
Complexity	High
Riskiness	Modest

3. Did the project include a monitoring and evaluation system for the implementation phase? **No**

If Yes, rate the extent to which the system met each of the following five criteria for a good M&E system:

Clear project and component objectives verifiable by indicators	
A structured set of indicators	
Requirements for data collection and management	
Institutional arrangements for capacity building	
Feedback from M&E	

4. For this particular project, rate the importance of the project's objectives:

Physical	Substantial	Institutional	Substantial
Financial (interest rates; pricing / tariff policies; cost recovery	High	Social	Modest
Economic		Environmental	Not Applicable
Macro-economic policies (fiscal; monetary; trade)	Not Applicable	Private sector development	Modest
Sector policies	High	Other (specify):	

B1a. Outcomes — Relevance

1. Indicate the relevance of each of the project's objectives in terms of the Bank's / Borrower's current country or sectoral objectives:

Physical	Substantial
Financial (interest rates; pricing / tariff policies; cost recovery)	High
Economic	
Macro-economic policies (fiscal; monetary; trade)	Not Applicable
Sector policies	Not Applicable
Institutional	Substantial
Social	Substantial
Environmental	Not Applicable
Private sector development	Modest
Other (specify):	

2. Summary Rating of Relevance

Rate the extent to which, as a whole, the project's goals were consistent with the Bank's / Borrower's strategies, taking account of the relevance and relative importance of each of the project's objectives: Substantial

Average rating (weighted by scores on relative importance) Substantial

If your overall rating differs from the average rating, please comment on reasons for this difference:

B1b. Outcomes — Efficacy

1. Indicate the extent to which each of the following objectives was in fact accomplished:

Physical	Substantial
Financial (interest rates; pricing / tariff policies; cost recovery	High
Economic	
Macro-economic policies (fiscal; monetary; trade)	Not Applicable
Sector policies	Not Applicable
Institutional	Modest
Social	Modest
Environmental	Not Applicable
Private sector development	Modest
Other (specify):	

2. Summary Rating of Efficacy

Rate the efficacy of the project, taking account of the relative importance of the objectives and the extent to which they were accomplished: Substantial

Average rating (weighted by scores on relative importance) Substantial

If your overall rating differs from the average rating, please comment on reasons for this difference:

B1b. Outcomes — Efficacy (cont'd)

3. Rate the extent to which each of the following factors affected the achievement of this project's objectives:

World markets / prices	No Effect	Performance of contractors / consultants	No Effect
Natural events	No Effect	War / civil disturbance	No Effect
Cofinancier(s) performance	No Effect	Other (specify):	

B1c. Outcomes — Efficiency

1. Is an **Economic Rate of Return** (ERR) available for this project? ○ Yes ◉ No

If No, is a **Financial Rate of Return** (FRR) available? ○ Yes ◉ No

If a rate of return is available, provide the following information (in percent):

		Point Value	Range	Weighted Average	Coverage / Scope
At Appraisal	◉ Not Available ○ Not Applicable		From : To :		
At Completion	◉ Not Available ○ Not Applicable		From : To :		

2. Was another measure of efficiency provided? ○ Yes ◉ No

If Yes, then answer the following:

Measure used	
Coverage / scope of measure	
Comparison to appraisal estimate	

3. If no measure of efficiency was provided for this project, would it have been reasonable to expect one? ◉ Yes ○ No

If Yes, explain:

Cost effectiveness analysis could have been performed for some components, including pharmaceutical reforms.

4. Rate the quality of the ex-post economic analysis according to the following criteria:

Soundness of analysis		Overall rating of quality of analysis	
Conduct of sensitivity / risk analysis		Average rating	
Consideration of institutional constraints to achieving results		If your overall rating differs from the average rating, please comment on reasons for this difference:	
Extent to which benefits accrue to target population			
Consideration of environmental externalities			
Consideration of fiscal impact			
Consideration of alternatives to meeting objectives			

B1c. Outcomes — Efficiency (cont'd)

5. Summary Rating of Efficiency

Rate overall to what extent the project accomplished its goals efficiently:	Modest	If your overall rating differs from the average rating, please comment on reasons for this difference:
Average rating		Proejct likely to contribute to sector efficiency, but long delays in early years of project were clearly inefficient.

B1d. Outcomes — Summary

1. SUMMARY OUTCOME RATING

Rate the project's outcome (i.e., the extent to which it achieved relevant objectives), taking account of its relevance, efficacy, and efficiency:	Satisfactory
Average rating	Marginally Satisfactory
If your overall rating differs from the average rating, please comment on reasons for this difference:	Substantial progress and latter years, particularly with regard to sector reforms, compensate for initial delays and shortcomings in project design.

B2. Sustainability

1. Rate the project's sustainability in terms of the following:

Technical viability	Positive	Policy environment	Positive
Financial viability	No Effect	Institution / management effectiveness	Positive
Economic viability	Positive	Local participation	Positive
Social conditions	Positive	Other (specify):	
Environmental concerns	No Effect		
Government commitment	Positive		

2. SUMMARY SUSTAINABILITY RATING

Rate the probability of maintaining the project's relevant development achievements generated or expected to be generated:	Uncertain
Average rating	Uncertain
If your overall rating differs from the average rating, please comment on reasons for this difference:	

B3. Institutional Development

1. Was this project directed primarily toward Institutional Development?
   - ○ Yes
   - ● No

2. If not, did the project contain components with significant Institutional Development objectives?
   - ● Yes
   - ○ No

3. Did the project's Institutional Development activities include each of the following:

Establishment of a new organization	No
Elimination of an existing organization	No
Restructuring / privatizing of an organization	Yes

4. For this particular project, rate the relevance of the following Institutional Development objectives:

National capacity	
Economic management	Not Applicable
Civil service reform	Not Applicable
Financial intermediation	Not Applicable
Legal / regulatory system	Not Applicable
Sectoral capacity	Substantial
Other (specify):	
Agency capacity	
Planning / policy analysis	Substantial
Management	Substantial
Skills upgrading	Substantial
MIS	Modest
Other (specify):	
NGO Capacity	Not Applicable

5. For this project, rate the extent to which each of the following ID objectives was achieved:

National capacity	
Economic management	Not Applicable
Civil service reform	Not Applicable
Financial intermediation	Not Applicable
Legal / regulatory system	Not Applicable
Sectoral capacity	Substantial
Other (specify):	
Agency capacity	
Planning / policy analysis	Substantial
Management	Substantial
Skills upgrading	Substantial
MIS	Modest
Other (specify):	
NGO Capacity	Not Applicable
Overall ID Efficacy	Modest

6. SUMMARY INSTITUTIONAL DEVELOPMENT IMPACT RATING

Rate the extent to which, as a whole, the project resulted in improvement of the country's/sector's ability to effectively use its human, organizational, and financial resources: Substantial

Average rating: Substantial

If your overall rating differs from the average rating, please comment on reasons for this difference:

C1. Bank Performance

1. To what extent did each of the following apply during project identification / preparation:

Involvement of government	Modest
Involvement of beneficiaries	Negligible
Project consistency with Bank strategy for country	Substantial
Grounding in economic and sector work (ESW)	Modest
Other (specify):	

Overall rating on identification / preparation: Unsatisfactory

Average rating: Unsatisfactory

If your overall rating differs from the average rating, please comment on reasons for this difference:

2. Indicate how well the Bank took account of the following during project appraisal:

Technical analysis (inc. alternatives)	Modest
Financial analysis (inc. funding provisions, fiscal impact)	Modest
Cost-benefit analysis (incl.ERR)	Not Applicable
Institutional capacity analysis	Modest
Social and stakeholder analysis	Modest
Environmental analysis	Not Applicable
Risk assessment (inc. adequacy of conditionalities)	Negligible
Incorporation of M&E indicators	Negligible
Incorporation of lessons learned	Modest
Readiness for implementation	Modest
Suitability of lending instrument	Substantial

Overall rating on appraisal: Unsatisfactory

Average rating: Unsatisfactory

If your overall rating differs from the average rating, please comment on reasons for this difference:

3. Considering the identification / preparation and appraisal processes discussed above, rate the overall quality of the project at the time of Board approval (Quality at Entry): Unsatisfactory

4. Indicate the adequacy of Bank project supervision in the following areas:

Reporting on project implementation progress	Modest
Identification / assessment of implementation problems	Substantial
Use of performance indicators	Modest
Enforcement of Borrower provision of M&E data	Substantial
Advice to implementing agency	High
Enforcement of loan covenants / exercise of remedies	Substantial
Flexibility in suggesting / approving modifications	High
Other (specify):	

Overall rating on supervision: Satisfactory

Average rating: Satisfactory

If your overall rating differs from the average rating, please comment on reasons for this difference:

C1. Bank Performance (cont'd)

5. SUMMARY RATING OF BANK PERFORMANCE

Rate the Bank's overall performance, taking account of identification / preparation, appraisal, and supervision activities:	Satisfactory
Average rating	Unsatisfactory
If your overall rating differs from the average rating, please comment on reasons for this difference:	Improved supervision performance, including project restructuring after midterm review, compensated for unsatisfactory quality at entry.

C2. Borrower Performance

1. Rate the Borrower / Implementing Agency performance on the preparation of this project: Satisfactory

2. Rate the extent to which government / implementing agency performance on the following dimensions supported project implementation:

Dimensions generally subject to government control

Macro policies / conditions	Modest	Administrative procedures	Substantial
Sector policies / conditions	Substantial	Cost changes	Substantial
Government commitment	Substantial	Implementation delays	Modest
Appointment of key staff	Substantial	Other (specify):	
Counterpart funding	Modest		

Dimensions generally subject to implementing agency control

Management	Substantial	Use of technical assistance	Substantial
Staffing	Substantial	Beneficiary participation	Substantial
Cost changes	Modest	Other (specify):	
Implementation delays	Substantial		

C2. Borrower Performance (cont'd)

3. Summary Rating of Borrower Performance on Project Implementation

Overall rating: Satisfactory

Average rating: Satisfactory

If your overall rating differs from the average rating, please comment on reasons for this difference:

4. Rate Borrower compliance with loan covenants / commitments:

Unsatisfactory

5. SUMMARY RATING OF BORROWER PERFORMANCE

Overall rating: Satisfactory

Average rating: Satisfactory

If your overall rating differs from the average rating, please comment on reasons for this difference:

D. Special Themes

1. Indicate whether each of the following social concerns was a major project emphasis:

Gender related issues	No
Settlement / resettlement	No
Beneficiary participation	Yes
Community development	No
Skills development	Yes
Nutrition and food security	Yes
Health improvement	Yes
Other (specify):	

2. Did the project have an unintended or unexpected effect on social concerns, regardless of the project's objectives?

No

If Yes, was the effect positive or negative?

3. Was this a Poverty Targeted Intervention? ○ Yes ● No

Did the project place a major emphasis on poverty alleviation? ● Yes ○ No

If Yes:

Did it emphasize broad-based growth with labor absorption? ○ Yes ● No

Did it emphasize human development (education, health, or nutrition)? ● Yes ○ No

Did it emphasize the provision of a social safety net? ○ Yes ● No

4. Indicate whether each of the following environmental concerns was a major project emphasis:

Natural resource management	No
Air / water / soil quality	No
Urban environmental quality	No
Other (specify):	

D. Special Themes (cont'd)

5. Did the project have an unintended or unexpected effect on environmental concerns, regardless of the project's objectives?

No

If Yes, was the effect positive or negative?

7. Rate the priority of the project for audit

Low

8. Rate the priority of the project for impact evaluation

Low

6. Indicate whether each of the following private sector development (PSD) concerns was a major project emphasis:

Improvement in legal or incentive framework designed to foster PSD (e.g., trade, pricing)	No
Restructuring / privatization of public enterprises	No
Financial sector development	No
Direct government financial and / or technical assistance to the private sector	No
Other (specify):	

E. Rating of ICR

1. Rate the quality of the ICR by the following characteristics:

Analysis	
Coverage of important subjects	Satisfactory
Ex-post economic analysis	Not Available
Soundness of analysis	
Internal consistencies	Satisfactory
Evidence complete / convincing	Satisfactory
Adequacy of lessons learned	Satisfactory
Aide-memoire of the ICR mission	Satisfactory
Future operation of project	
Plan for future project operation	Satisfactory
Performance indicators for the project's operational phase	Satisfactory
Plan for monitoring and evaluation of future operation of the project	Satisfactory
Borrower / cofinancier inputs	
Borrower input to ICR	Satisfactory
Borrower plan for future project operation	Satisfactory
Borrower comments on ICR	Satisfactory
Cofinancier comments on ICR	Not Available

2. SUMMARY RATING OF ICR

Rate the quality of the ICR:	Satisfactory
Average rating	Satisfactory

If your overall rating differs from the average rating, please comment on reasons for this difference:

E. Rating of ICR (cont'd)

3. Rate the quality of borrower participation in the project completion process on the following:

Analysis	Exemplary	Focus on lessons learned	Satisfactory
Concern with development impact	Satisfactory	Self-evaluation	Satisfactory
Internal consistency	Exemplary	Evaluation of Bank	Satisfactory
Evidence to justify views	Satisfactory		

F. Summary of Ratings

1. SUMMARY OF RATINGS

	ICR	ES
Outcome	Satisfactory	Satisfactory
Sustainability	Uncertain	Uncertain
Institutional Development efficacy / impact	Modest	Substantial
Bank performance	Satisfactory	Satisfactory
Borrower performance	Satisfactory	Satisfactory
ICR quality		Satisfactory

2. Explain any differences between OED ratings and those in the ICR:

Although not all of the institutional objectives were fully attained, the project made progress on a number of key institutional and policy reforms, despite the low-income country context.

G. Overall Judgements / Miscellaneous Comments

1. Enter any overall judgements or rationales and miscellaneous comments below.

Timothy A. Johnston
04/24/2000 01:07 PM

Extn: 31750 OEDST
Subject: Re: TANZANIA: Health and Nutrition Project (Credit 2098)
OED Review of Implementation Completion Report

Please add to the ICR file.
Tim

---------- Forwarded by Timothy A. Johnston/Person/World Bank on 04/24/2000 01:05 PM ----------

Chiyo Kanda 04/24/2000 10:19 AM

Extn: 82632 AFTH1
To: Gregory K. Ingram cc: James W. Adams, Prem C. Garg, Eduardo A. Doryan, James Christopher Lovelace, Ruth Kagia,
Subject: Re: TANZANIA: Health and Nutrition Project (Credit 2098)
OED Review of Implementation Completion Report

Thank you for sending me the attached. It is good to see the positive assessments and "upgrading" of the ICR rating.

If I may, the only thing I would like to add is the project's impact on drug availability.

One is through the capitalization of the Medical Stores Department (formerly the Central Medical Stores) through injection of drugs as well as its adherence to a strict cash-and-carry system. When the project started, the CMS was broke, did not have enough drugs on the shelf, with lots of incollectable "accounts receivable" for the drugs it provided to health facilities.

Another is the substantial improvement observed in drug availability at dispensaries/health centers in the districts implementing the Community Health Funds. According to an assessment carried out in 2 CHF districts, the stock-out rates of essential drugs and supplies dramatically decreased after the introduction of the CHF. The study checked the number of (primary) facilities in Igunga district (the first district which introduced a CHF in 1996), which had a stock out of more than one week for 31 most frequently used drugs. In 1996, a stock-out of all the 31 items was experienced by one or more facilities, of which 12 items were out of stock for at least one week in more than half of the facilities. In 1999, almost all the items were always in stock (only 1 or 2 facilities experienced a stock-out), except three items (Laboratory reagents, Praziquantel tablets, and cough mixture). In Singida where a CHF was introduced in 1998, the situation was similar.

Thanks.
Chiyo

10 out 114 Districts
Facility revolving Funds 4 regions
23 - districts,

Gregory K. Ingram

Gregory K. Ingram
04/20/2000 03:29 PM

Extn: 31052 OEDST
Sent by: Helen Phillip
To: James W. Adams cc: Prem C. Garg, Eduardo A. Doryan, James Christopher Lovelace, Ruth Kagia, Helen Saxenian, St
Subject: TANZANIA: Health and Nutrition Project (Credit 2098)
OED Review of Implementation Completion Report

Attached for your review is OED's Evaluation Summary for the above project. This form contains OED's ratings and comments on the ICR. Any comments you may have should reach me no later than c.o.b. April 26, 2000.

Gregory K. Ingram
Manager
Sector and Thematic Evaluations Group

---------- Forwarded by Maria Pilar Barquero/Person/World Bank on 04/19/2000 02:20 PM ----------

ICR Review - Evaluation Summary

Operations Evaluation Department

Date Created: 04/11/2000 01:16:34 PM
Last Updated: 04/18/2000 03:56:54 PM
Status: Open

1. Project Data:		ES Date Posted:		
PROJ ID: P002774 OEDID: C2098			Appraisal	Actual
Project Name:	Health & Nutrition	Project Costs (US$M)	70	51.77
Country:	Tanzania	Loan/Credit (US$M)	47.6	47.6
Sector, Major Sect.:	Basic Health, Population Health & Nutrition	Cofinancing (US$M)	15	N.A.
L/C Number:	C2098			
		Board Approval (FY)		1990
Partners involved:	Gov't of Belgium, ODA/DfID, Danida, UNFPA, SDC	Closing Date	06/30/96	06/30/99

Prepared by:	Reviewed by:	Group Manager:	Group:
Timothy A. Johnston/Person/World Bank	Roy Gilbert/Person/World Bank	Gregory K. Ingram/Person/World Bank	OEDST

2. Project Objectives and Components

a. Objectives

The project sought to raise the quality, coverage, and effectiveness of family planning, nutrition and basic health services through provision of support to critical and strategic elements of the HNP sector.

b. Components

Project components included: (i) institutional capacity strengthening for health planning and policy formation; (ii) manpower development and training in the health sector; (iii) sustainable provision and financing of pharmaceuticals and medical supplies; (iv) control of micronutrient deficiency; (v) implementation of the national population policy; (vi) enhance rural primary health care through a trial implementation of a revised PHC strategy; and (vii) strengthened urban primary health care in Dar es Salaam.

c. Comments on Project Cost, Financing and Dates

The project was approved in March 1990. The project closing date was extended twice, first in June 1996 to accommodate delays the first three years of project effectiveness, and the second in April 1998 to allow pretest alternative financing schemes and support preparation of broader sector reform initiatives.

3. Achievement of Relevant Objectives:

Most of the relevant objectives were achieved, although with significant delays.

(i) The *Strengthening National HNP Systems* component achieved most of its objectives. Project-sponsored TA and training strengthened planning and technical capacity at both district and national level. Project conditions contributed to several key policy reforms, including increased budget allocations to health (from 7 percent in the late 1980s to 12 percent in 1998/99); introduction of cost-sharing in government facilities; and autonomization of the Central Medical Stores. Pharmaceutical reforms and direct project support for drug procurement improved drug availability, particularly in districts with revolving drug funds. The Micronutrient Deficiency Control component appeared to have only mixed impact, however, and the National Population Policy component was unsuccessful.

(ii) *Strengthening Rural Primary Health Care*: This component had modest success in increasing community involvement, but participation focused on rehabilitating health facilities rather than nutritional activities. Facility rehabilitation and equipment have improved facility quality in rural clinics and district hospitals, but the impact on utilization was lower than expected.

(iii) *Dar Es Salaam Urban Health Project:* This component was fully satisfactory, and helped rehabilitate 60 urban facilities, establish local health boards, introduce cost-sharing, and establish a preventive maintenance program.

4. Significant Outcomes/Impacts:
The project eventually contributed to important sector reforms and policy changes, particularly for health financing and the pharmaceutical sector. These included autonomization of the state pharmaceutical agency; establishment of revolving drug funds at facility level; implementation of cost recovery and community financing for local health services; and a doubling of the percentage budget allocation to the health sector. These measures should contribute to the financial sustainability of the sector. The project also contributed to improved basic infrastructure in Dar es Salaam and 10 of the poorest districts, and piloted an innovative maintenance scheme for urban health centers, which could be more widely replicated, particularly at district level. Training provided through the project has helped increase capacity at both central and district levels. The project help lay the groundwork for the current multi-donor Health Sector Reform Program, which should help alleviate the severe fragmentation that has characterized previous donor support to the Tanzania health sector.

5. Significant Shortcomings (including non-compliance with safeguard policies):
The project suffered from inadequate quality at entry, because of overly complex design involving multiple implementing ministries; inadequate ownership and stakeholder involvement; and poorly designed cross-conditionalities, which resulted in little disbursement for the first three years. A mid-term review in 1993 led to project restructuring in 1996, and subsequent improvements in Bank and borrower implementation performance. Shortages of counterpart funds further delayed implementation in the mid-1990s, but the situation improved following an improved macroeconomic situation in the late-1990s. Bank performance in initial project design and supervision was unsatisfactory, and supervision was disrupted by the transfer of the Tanzania portfolio from the southern Africa region to East Africa in the late 1980s.

6. Ratings:	ICR	OED Review	Reason for Disagreement/Comments
Outcome:	Satisfactory	Satisfactory	Substantial progress in final years compensates for unsatisfactory quality at entry.
Institutional Dev.:	Partial	Substantial	Progress on difficult pharmaceutical and financial reforms merit a rating of "substantial"
Sustainability:	Uncertain	Uncertain	Given Tanzania's heavy reliance on donor funds for sector financing, sustainability remains a challenge.
Bank Performance:	Satisfactory	Satisfactory	
Borrower Perf.:	Satisfactory	Satisfactory	
Quality of ICR:		Satisfactory	

7. Lessons of Broad Applicability:
Relevant lessons include:

- Complex policy reforms are better pursued as project outcomes rather than up-front conditionalities;
- The involvement of multiple agency/ministries must be weighed carefully -- the potential benefits can be undermined by the difficulties of intersectoral coordination;
- Project components should consist of closely-related activities; otherwise supervision becomes extremely difficult
- Macroeconomic analysis and policy work should be closely coordinated with sector dialogue, and can be mutually enhancing
- Baseline data and clear performance targets are essential for effective project supervision and impact evaluation

8. Audit Recommended? ○ Yes ● No

9. Comments on Quality of ICR:
ICR was well-written, but included little data on outcomes at the end-user level. Incorporation of findings from an independent impact evaluation conducted in early 2000 would have strengthened the ICR. The stakeholder ICR workshop (summarized in Appendix B) is a "good practice" example that could be more widely replicated.

****

Chiyo Kanda
Economist, Human Development 1, Africa Region
World Bank (Room J10-027)
1818 H Street, N.W.
Washington, D.C. 20433
Tel: 202-458-2632
Fax: 202-473-8299

Tim Johnston
Health, Nutrition, and Population Cluster Coordinator
Operations Evaluation Department
World Bank, Room H3-445
Tel: 202/473-1750
Fax: 202/522-3123

To: Maria Pilar Barquero

Timothy A. Johnston
04/24/2000 01:07 PM

Extn: 31750 OEDST
Subject: Re: TANZANIA: Health and Nutrition Project (Credit 2098)
OED Review of Implementation Completion Report

Please add to the ICR file.
Tim

---------- Forwarded by Timothy A. Johnston/Person/World Bank on 04/24/2000 01:05 PM ----------

Chiyo Kanda 04/24/2000 10:19 AM

Extn: 82632 AFTH1
To: Gregory K. Ingram cc: James W. Adams, Prem C. Garg, Eduardo A. Doryan, James Christopher Lovelace, Ruth Kagia, H
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Gregory K. Ingram

Gregory K. Ingram
04/20/2000 03:29 PM

Extn: 31052 OEDST

Sent by: Helen Phillip

To: James W. Adams cc: Prem C. Garg, Eduardo A. Doryan, James Christopher Lovelace, Ruth Kagia, Helen Saxenian, Ste
Subject: TANZANIA: Health and Nutrition Project (Credit 2098)
OED Review of Implementation Completion Report

Attached for your review is OED's Evaluation Summary for the above project. This form contains OED's ratings and comments on the ICR. Any comments you may have should reach me no later than c.o.b. April 26, 2000.

Gregory K. Ingram
Manager
Sector and Thematic Evaluations Group

John A. Innes
04/21/2000 02:15 PM

Extn: 35826 ECSHD
Subject: Re: Tanzania Project

Pilar:

The relevant staff at appraisal were:

Task Manager	John Innes
Division Chief	David de Ferranti
Department Director	Sven Sandstrom

John Innes
Program Team Leader
(Bulgaria HD and Romania SP)
Tel 1(202) 473-5826
EM. jinnes @worldbank.org

To: Maria Pilar Barquero

THE WORLD BANK GROUP

ROUTING SLIP	DATE: April 19, 2000

NAME	ROOM. NO.
Mr. Gregory Ingram, Manager, OEDST	H3-373

	URGENT		PER YOUR REQUEST
	FOR COMMENT		PER OUR CONVERSATION
	FOR ACTION		NOTE AND FILE
✓	FOR APPROVAL/CLEARANCE		FOR INFORMATION
	FOR SIGNATURE		PREPARE REPLY
	NOTE AND CIRCULATE		NOTE AND RETURN

RE: Tanzania: Health and Nutrition Project (Credit 2098 TZ)
Implementation Completion Report

REMARKS:

This ICR has passed the OED's Panel review and requires your approval before being sent to the Region.

FROM	ROOM NO.	EXTENSION
Timothy Johnston, Task Manager, OEDST		**31750**

Maria Pilar Barquero
04/19/2000 02:20 PM

Extn: 31757 OEDST ***** DRAFT *****
Subject: TANZANIA: Health and Nutrition Project (Credit 2098)
OED Review of Implementation Completion Report

This ICR has been approved by you and it is now ready to go to the Region.

To: James Adams, Country Director (AFMTZ)

Attached for your review is OED's Evaluation Summary for the above project. This form contains OED's ratings and comments on the ICR. Any comments you may have should reach me no later than c.o.b. [5 working days], 1999.

Gregory K. Ingram
Manager
Sector and Thematic Evaluations Group

Distribution:

cc: Messrs./Mmes. P. Garg (MDOQA); Eduardo Doryan (HDNVP); Chris Lovelace (HDNHE); Ruth Kagia (HDNVP); Helen Saxenian (HDNHE); Stephen Commins (HDNVP); M. Louise Fox (HDNVP); R. Brigish (AFCTZ); D. Mutumbuka, C. Kanda, T. Johnston (OEDST)

---------- Forwarded by Maria Pilar Barquero/Person/World Bank on 04/19/2000 02:20 PM ----------

ICR Review - Evaluation Summary

Operations Evaluation Department

Date Created: 04/11/2000 01:16:34 PM
Last Updated: 04/18/2000 03:56:54 PM
Status: Open

1. Project Data:		ES Date Posted:		
PROJ ID: P002774 **OEDID:** C2098			**Appraisal**	**Actual**
Project Name:	Health & Nutrition	**Project Costs (US$M)**	70	51.77
Country:	Tanzania	**Loan/Credit (US$M)**	47.6	47.6
Sector, Major Sect.:	Basic Health, Population Health & Nutrition	**Cofinancing (US$M)**	15	N.A.
L/C Number:	C2098			
		Board Approval (FY)		1990
Partners involved:	Gov't of Belgium, ODA/DfID, Danida, UNFPA, SDC	**Closing Date**	06/30/96	06/30/99

Prepared by:	Reviewed by:	Group Manager:	Group:
Timothy A. Johnston/Person/World Bank	Roy Gilbert/Person/World Bank	Gregory K. Ingram/Person/World Bank	OEDST

2. Project Objectives and Components

a. Objectives

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c. Comments on Project Cost, Financing and Dates

The project was approved in March 1990. The project closing date was extended twice, first in June 1996 to accommodate delays the first three years of project effectiveness, and the second in April 1998 to allow pretest alternative financing schemes and support preparation of broader sector reform initiatives.

3. Achievement of Relevant Objectives:
Most of the relevant objectives were achieved, although with significant delays.
(i) The *Strengthening National HNP Systems* component achieved most of its objectives. Project-sponsored TA and training strengthened planning and technical capacity at both district and national level. Project conditions contributed to several key policy reforms, including increased budget allocations to health (from 7 percent in the late 1980s to 12 percent in 1998/99); introduction of cost-sharing in government facilities; and autonomization of the Central Medical Stores. Pharmaceutical reforms and direct project support for drug procurement improved drug availability, particularly in districts with revolving drug funds. The Micronutrient Deficiency Control component appeared to have only mixed impact, however, and the National Population Policy component was unsuccessful.
(ii) *Strengthening Rural Primary Health Care*: This component had modest success in increasing community involvement, but participation focused on rehabilitating health facilities rather than nutritional activities. Facility rehabilitation and equipment have improved facility quality in rural clinics and district hospitals, but the impact on utilization was lower than expected.
(iii) *Dar Es Salaam Urban Health Project:* This component was fully satisfactory, and helped rehabilitate 60 urban facilities, establish local health boards, introduce cost-sharing, and establish a preventive maintenance program.

4. Significant Outcomes/Impacts:
The project eventually contributed to important sector reforms and policy changes, particularly for health financing and the pharmaceutical sector. These included autonomization of the state pharmaceutical agency; establishment of revolving drug funds at facility level; implementation of cost recovery and community financing for local health services; and a doubling of the percentage budget allocation to the health sector. These measures should contribute to the financial sustainability of the sector. The project also contributed to improved basic infrastructure in Dar es Salaam and 10 of the poorest districts, and piloted an innovative maintenance scheme for urban health centers, which could be more widely replicated, particularly at district level. Training provided through the project has helped increase capacity at both central and district levels. The project help lay the groundwork for the current multi-donor Health Sector Reform Program, which should help alleviate the severe fragmentation that has characterized previous donor support to the Tanzania health sector.

5. Significant Shortcomings (including non-compliance with safeguard policies):
The project suffered from inadequate quality at entry, because of overly complex design involving multiple implementing ministries; inadequate ownership and stakeholder involvement; and poorly designed cross-conditionalities, which resulted in little disbursement for the first three years. A mid-term review in 1993 led to project restructuring in 1996, and subsequent improvements in Bank and borrower implementation performance. Shortages of counterpart funds further delayed implementation in the mid-1990s, but the situation improved following an improved macroeconomic situation in the late-1990s. Bank performance in initial project design and supervision was unsatisfactory, and supervision was disrupted by the transfer of the Tanzania portfolio from the southern Africa region to East Africa in the late 1980s.

6. Ratings:	ICR	OED Review	Reason for Disagreement/Comments
Outcome:	Satisfactory	Satisfactory	Substantial progress in final years compensates for unsatisfactory quality at entry.
Institutional Dev.:	Partial	Substantial	Progress on difficult pharmaceutical and financial reforms merit a rating of "substantial"
Sustainability:	Uncertain	Uncertain	Given Tanzania's heavy reliance on donor funds for sector financing, sustainability remains a challenge.
Bank Performance:	Satisfactory	Satisfactory	
Borrower Perf.:	Satisfactory	Satisfactory	
Quality of ICR:		Satisfactory	

7. Lessons of Broad Applicability:
Relevant lessons include:

- Complex policy reforms are better pursued as project outcomes rather than up-front conditionalities;
- The involvement of multiple agency/ministries must be weighed carefully -- the potential benefits can be undermined by the difficulties of intersectoral coordination;
- Project components should consist of closely-related activities; otherwise supervision becomes extremely difficult
- Macroeconomic analysis and policy work should be closely coordinated with sector dialogue, and can be mutually enhancing
- Baseline data and clear performance targets are essential for effective project supervision and impact evaluation

8. Audit Recommended? ○ Yes ● No

9. Comments on Quality of ICR:
ICR was well-written, but included little data on outcomes at the end-user level. Incorporation of findings from an independent impact evaluation conducted in early 2000 would have strengthened the ICR. The stakeholder ICR workshop (summarized in Appendix B) is a "good practice" example that could be more widely replicated.

To: Gregory K. Ingram
cc: Adala T. Bruce-Konuah

Project	Project Type	Loan Credit
420	**ICR**	CR 2098

Country
TANZANIA - Health and Nutrition

Prepared by	Date Received by Panel
T. JOHNSTON	4/10/00

Assigned to	Date Assigned
GILBERT R.	4/11/00

Review Completed
APM- 13, 2000

Comments
Upon completing your review, please return the package to Nishi (Room H3 160) for logging and forwarding to the corresponding task manager. The originating task manager would be expected to resubmit the final package for your initials within the prescribed 7 working days from this date.

Tim: Your evaluation brings out some v. important points. Pls see comments/suggestions in ES + PIF, as well as references to ICR.

ICR Review - Evaluation Summary

Operations Evaluation Department

Date Created: 04/11/2000 01:16:34 PM
Last Updated: 04/11/2000 03:25:58 PM
Access Delegation List:Maria Pilar Barquero/Person/World Bank
Status: Open

1. Project Data:		ES Date Posted:	Appraisal	Actual
PROJ ID:	P002774 OEDID: C2098			
Project Name:	Health & Nutrition	Project Costs (US$M)	70	51.77
Country:	Tanzania	Loan/Credit (US$M)	47.6	47.6
Sector, Major Sect.:	Basic Health, Population Health & Nutrition	Cofinancing (US$M)	15	N.A.
L/C Number:	C2098			
		Board Approval (FY)		90
Partners involved:	Gov't of Belgium, ODA/DfID, Danida, UNFPA, SDC	Closing Date	06/30/96	06/30/99

Prepared by:	Reviewed by:	Group Manager:	Group:
Timothy A. Johnston		Gregory K. Ingram	, OEDST

2. Project Objectives and Components

a. Objectives

The project sought to raise the quality, coverage, and effectiveness of family planning, nutrition and basic health services through provision of support to critical and strategic elements of the HNP sector.

b. Components

Project components included: (i) institutional capacity strengthening for health planning and policy formation; (ii) manpower development and training in the health sector; (iii) sustainable provision and financing of pharmaceuticals and medical supplies; (iv) control of micronutrient deficiency; (v) implementation of the national population policy; (vi) enhance rural primary health care through a trial implementation of a revised PHC strategy; and (vii) strengthened urban primary health care in Dar es Salaam.

c. Comments on Project Cost, Financing and Dates

The project closing date was extended twice, first in June 1996 to accommodate delays the first three years of project effectiveness, and the second in April 1998 to allow pretest alternative financing schemes and support preparation of broader sector reform initiatives.

DATE OF APPROVAL.

3. Achievement of Relevant Objectives:

Most of the relevant objectives were achieved, although with significant delays. The implementation of the national population policy was less unsatisfactory, and the micronutrient component appears to have had limited impact.

marginally SAT or marginally UNSAT?

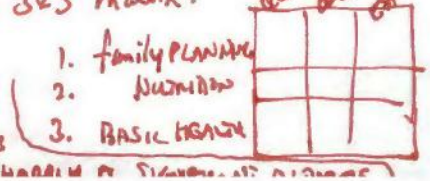
of the country, of the city?

4. Significant Outcomes/Impacts:

The project eventually contributed to important sector reforms and policy changes, particularly for health financing and the pharmaceutical sector. These included autonomization of the state pharmaceutical agency; establishment of revolving drug funds that facility level; implementation of cost recovery and community financing for local health services; and a doubling of the percentage budget allocation to the health sector. These measures should contribute to the financial sustainability of the sector. The project also contributed to improved basic infrastructure in Dar es Salaam and 10 of the poorest districts, and piloted and innovative maintenance scheme for urban health centers, which could be more widely replicated. Training provided through the project has helped increase capacity at both central and district levels. The project help lay the groundwork for the current multi-donor Health Sector Reform Program, which should help alleviate the severe fragmentation that has characterized previous donor support to the Tanzania health sector.

?

The project objectives (para 2 (a)) seem to be in the former of a 3x3 matrix:



You could enrich the achievement of objectives statement by referring to each of the 3 topics, describing achievements, failures according to each dimension. Current statement in section 3 is very bland.

UNCLEAR MEANING. ARE YOU SAYING THEY SHOULD BE REPLICATED? IN ANY CASE IT APPEARS HAS NOT

5. Significant Shortcomings (including non-compliance with safeguard policies):
The project suffered from inadequate quality at entry, ~~including~~ overly complex design involving multiple implementing ministries; inadequate ownership and stakeholder involvement; and poorly designed and cross-conditionalities, which ~~meant that many of the~~ project ~~components did not~~ disburse for several years. A mid-term review in 1993 led to project restructuring in 1996, and subsequent improvements in Bank and borrower implementation ~~performance~~. Shortages of counterpart funds further delayed implementation in the mid-1990s, but the situation subsequently improved. Bank performance in initial project design and supervision was unsatisfactory, and supervision was negatively effected by the transfer of the Tanzania portfolio from the southern Africa region to East Africa in the late 1980s.

6. Ratings:	ICR	OED Review	Reason for Disagreement/Comments
Outcome:	Satisfactory	Satisfactory	Substantial progress in final years compensates for unsatisfactory quality at entry.
Institutional Dev.:	Partial	Substantial	Progress on difficult pharmaceutical and financial reforms merit a rating of "substantial"
Sustainability:	Uncertain	Uncertain	Given Tanzania's heavy reliance on donor funds for sector financing, sustainability remains a challenge.
Bank Performance:	Satisfactory	Satisfactory	
Borrower Perf.:	Satisfactory	Satisfactory	
Quality of ICR:		Satisfactory	

7. Lessons of Broad Applicability:
Relevant lessons include:

- complex policy reforms are better pursued as project outcomes rather than up-front conditionalities;
- ~~To reduce project complexity~~, the involvement of multiple agency/ministries must be weighed carefully against expected outcomes, and project components should be designed with an internal logic behind them.
- Macroeconomic analysis and policy work should be closely coordinated with sector dialogue, ~~and can be mutually~~ enhancing.
- Baseline data and clear performance targets are essential for effective project supervision and impact evaluation

8. Audit Recommended? ○ Yes ● No

9. Comments on Quality of ICR:
ICR was well-written, but included ~~relatively~~ little data ~~regarding~~ outcomes at the end-user level. Incorporation of findings from an independent impact evaluation conducted in early 2000 would have strengthened the ICR. The stakeholder ICR workshop (summarized in Appendix B) is a "good practice" example that could be more widely replicated.

THE WORLD BANK GROUP

ROUTING SLIP	DATE: April 11, 2000

NAME	ROOM. NO.
Mr. Ridley Nelson, Chair, ICR/PCN Review Panel	

	URGENT		PER YOUR REQUEST
	FOR COMMENT		PER OUR CONVERSATION
	FOR ACTION		NOTE AND FILE
✓	FOR APPROVAL/CLEARANCE		FOR INFORMATION
✓	FOR SIGNATURE		PREPARE REPLY
	NOTE AND CIRCULATE		NOTE AND RETURN

RE: TANZANIA—Health and Nutrition Project (C2098)
Implementation Completion Report

REMARKS:

Please find attached for panel review the above-mentioned ICR together with the Project Information Form, and a draft Evaluation Summary from the Manager, OEDST, to the Country Director concerned.

FROM	ROOM NO.	EXTENSION
Tim Johnston, Task Manager	**H3-445**	**31750**

ICR/PIF COVER SHEET

Run Date: 12/30/99

Proj ID : P002774 OED ID : C2098 Group: 10

Country:	Tanzania	
Project Description:	Health and Nutrition	
Sector:	04 / Human Resource	
Subsector:	04.05 / Pop., Health & Nutr.	
Lending Instrument Type:	SIL	
L/C:	C2098	
Original IDA/IBRD Commitments:	47,600,000	($US)
Total Cancellations:	0	($US)

Key Dates	ORIGINAL	ACTUAL
Approval		3/06/90
Signing/Agreement		3/07/90
Effectiveness	6/07/90	4/06/90
Closing	6/30/96	6/30/99
ICR Receipt in OED		12/30/99

EVALUATOR NAME: T. Johnston

EVALUATOR SIGNATURE: _____ DATE: _____

Please confirm the above information, sign and date this sheet and return a phot to Helen Sioris when the EVM/Regional memo/PIF packet is submitted to OED Direct

********** TO BE COMPLETED BY EVALUATION OFFICER **********

Date of Review: ____/____/____ (mm / dd / yy)

Name of Reviewer: _____

Type of Evaluation: PCR Review [ ] PAR Review [ ]

If this is a PAR Review, are there major differences in the judgements from those made in the PCR Review?

Yes [ ] No [ ]

If Yes, please discuss in detail on page 26 of the PIF

	ORIGINAL (mm/dd/yy)	LATEST (mm/dd/yy)
Date of Physical Completion		
Total Project Cost ($US mill)		
Applicable Disbursement Profile: (see note 11 in the PIF, page 31)		
Number of Supervision Missions:		

Note use of Borrower ICR workshop in "Comments" section

Oscan 1 page
473-8211 #6

12/30

THE WORLD BANK/IFC/M.I.G.A.

OFFICE MEMORANDUM

DATE: December 22, 1999

TO: Board Operations Division, Corporate Secretariat (MC 12-244)

FROM: James Adams, Country Director, AFMTZ

XTENSION: 555+237

SUBJECT: **TANZANIA-Health and Nutrition Project**
Implementation Completion Report

This is to confirm that I have cleared the Implementation Completion Report dated December 28, 1999 for the Tanzania Health and Nutrition Project (Credit No. 20980) for distribution to the Board.

Thank you.

- End of project impact evaluation - by external consultants in early 2000 - available?

Attachment: ICR cover page

cc: Helen Sioris, OED

Note from Gita Gopal - ICR says Gender not applicable - but can't be flagged in EVM

Tanzania - Health and Nutrition Project

Credit/Loan/Guarantee No.: C2098
Borrower: UNITED REPUBLIC OF TANZANIA
Other Parties:
Sector: HE - Human Resources/Health
Lending Instrument: SIL - Specific Investment Loan
Program Objective: PA - Poverty Alleviation
Environment Rating: C - No Environmental Assessment

Development Credit Agreement

CREDIT NUMBER 2098-TA

Development Credit Agreement

(Health and Nutrition Project)

between

UNITED REPUBLIC OF TANZANIA

and

INTERNATIONAL DEVELOPMENT ASSOCIATION

Dated March 7, 1990

CREDIT NUMBER 2098-TA

DEVELOPMENT CREDIT AGREEMENT

AGREEMENT, dated March 7, 1990, between UNITED REPUBLIC OF TANZANIA (the Borrower) and INTERNATIONAL DEVELOPMENT ASSOCIATION (the Association).

WHEREAS (A) the Borrower, having satisfied itself as to the feasibility and priority of the Project described in Schedule 2 to this Agreement, has requested the

Association to assist in the financing of the Project;

(B) the Borrower has requested from the Swiss Confederation a non-reimbursable contribution (the Swiss Contribution) in an amount approximately equivalent to $12,200,000 to assist in financing Part C of the Project on the terms and conditions set forth in an intergovernmental agreement to be entered into between the Borrower and Switzerland; and

(C) the Borrower intends to obtain from the Kingdom of Denmark, through the Danish International Development Association (DANIDA), a grant (the DANIDA Grant) in an amount approximately equivalent to $1,300,000 to assist in financing the Project;

(D) the Borrower intends to obtain from the Kingdom of Belgium a grant (the Belgian Grant) in an amount approximately equivalent to $1700,000 to assist in financing the Project;

(E) the Borrower intends to obtain from the United Nations Fund for Population Activities (UNFPA), a grant (the UNFPA Grant) in an amount approximately equivalent to $700,000 to assist in financing the Project;

WHEREAS the Association has agreed, on the basis, inter alia of the foregoing, to extend the Credit to the Borrower upon the terms and conditions set forth in this Agreement;

NOW THEREFORE the parties hereto hereby agree as follows:

ARTICLE I

General Conditions; Definitions

Section 1.01. The "General Conditions Applicable to Development Credit Agreements" of the Association, dated January 1, 1985, with the last sentence of Section 3.02 deleted (the General Conditions) constitute an integral part of this Agreement.

Section 1.02. Unless the context otherwise requires, the several terms defined in the General Conditions and in the Preamble to this Agreement have the respective meanings therein set forth and the following additional terms have the following meanings:

(a) "Special Accounts" means the accounts referred to in Section 2.02 (b) of this Agreement;

(b) "MOH" means the Borrower's Ministry of Health;

(c) "MLG" means the Borrower's Ministry of Local Government, Community Development, Cooperatives and Marketing;

(d) "CMS" means the Borrower's Central Medical Stores within MOH;

(e) "PHC" means Primary Health Care;

(f) "PHN" means Population, Health and Nutrition;

(g) "TCPD" means the Tanzanian Council for Population and Development;

(h) "TFNC" means the Tanzania Food and Nutrition Centre;

(i) "PSN" means the Program Support Network in MLG;

(j) "DMDT" means the Department of Manpower Development and Training in MOH;

(k) "PCC" means the Project Coordination Committee to be established by the Borrower under the Project;

(l) "Basic Package" means the basic package of PHC inputs for the initial implementation of the revised PHC Strategy in five of the ten selected districts under Part B of the Project; and

(m) "Project Preparation Advance" means the project preparation advance granted by the Association to the Borrower pursuant to an exchange of letters dated June 22, 1989, and July 14, 1989, between the Borrower and the Association.

ARTICLE II

The Credit

Section 2.01. The Association agrees to lend to the Borrower, on the terms and conditions set forth or referred to in this Agreement, an amount in various currencies equivalent to thirty-six million one hundred thousand Special Drawing Rights (SDR 36,100,000).

Section 2.02. (a) The amount of the Credit may be withdrawn from the Credit Account in accordance with the provisions of Schedule 1 to this Agreement for expenditures made (or, if the Association shall so agree, to be made) in respect of the reasonable cost of goods and services required for the Project described in Schedule 2 to this Agreement and to be financed out of the proceeds of the Credit.

(b) The Borrower shall, for the purposes of the Project, open and maintain in dollars two special accounts (the MOH Special Account and the MLG Special Account) in its Central Bank on terms and conditions satisfactory to the Association. Deposits into, and payments out of the Special Accounts shall be made in accordance with the provisions of Schedule 5 to this Agreement.

(c) Promptly after the Effective Date, the Association shall, on behalf of the Borrower, withdraw from the Credit Account and pay to itself the amount required to repay the principal amount of the Project Preparation Advance withdrawn and outstanding as of such date and to pay all unpaid charges thereon. The unwithdrawn balance of the authorized amount of the Project Preparation Advance shall thereupon be cancelled.

Section 2.03. The Closing Date shall be June 30, 1996, or such later date as the Association shall establish. The Association shall promptly notify the Borrower of such later date.

Section 2.04. (a) The Borrower shall pay to the Association a commitment charge on the principal amount of the Credit not withdrawn from time to time at a rate to be set by the Association as of June 30 of each year, but not to exceed the rate of one-half of one percent (1/2 of 1%) per annum.

(b) The commitment charge shall accrue: (i) from the date sixty days after the date of this Agreement (the accrual date) to the respective dates on which amounts shall be withdrawn by the Borrower from the Credit Account or cancelled; and (ii) at the rate set as of the June 30 immediately preceding the accrual date and at such other rates as may be set from time to time thereafter pursuant to paragraph (a) above. The rate set as of June 30 in each year shall be applied from the next date in that year specified in Section 2.06 of this Agreement.

(c) The commitment charge shall be paid: (i) at such places as the Association shall reasonably request; (ii) without restrictions of any kind imposed by, or in the territory of, the Borrower; and (iii) in the currency specified in this Agreement for the purposes of Section 4.02 of the General Conditions or in such other eligible currency or currencies as may from time to time be designated or selected pursuant to the provisions of that Section.

Section 2.05. The Borrower shall pay to the Association a service charge at the rate of three-fourths of one percent (3/4 of 1%) per annum on the principal amount of the Credit withdrawn and outstanding from time to time.

Section 2.06. Commitment charges and service charges shall be payable semiannually on June 15 and December 15 in each year.

Section 2.07. (a) Subject to paragraphs (b) and (c) below, the Borrower shall repay the principal amount of the Credit in semi-annual installments payable on each June 15 and December 15 commencing June 15, 2000, and ending December 15, 2029. Each installment to and including the installment payable on December 15, 2009, shall be one percent (1%) of such principal amount, and each installment thereafter shall be two percent (2%) of such principal amount.

(b) Whenever: (i) the Borrower's gross national product per capita, as determined by the Association, shall have exceeded $790 in constant 1985 dollars for five consecutive years; and (ii) the Bank shall consider the Borrower creditworthy for Bank lending, the Association may, subsequent to the review and approval thereof by the Executive Directors of the Association and after due consideration by them of the development of the Borrower's economy, modify the terms of repayment of

installments under paragraph (a) above by requiring the Borrower to repay twice the amount of each such installment not yet due until the principal amount of the Credit shall have been repaid. If so requested by the Borrower, the Association may revise such modification to include, in lieu of some or all of the increase in the amounts of such installments, the payment of interest at an annual rate agreed with the Association on the principal amount of the Credit withdrawn and outstanding from time to time, provided that, in the judgment of the Association, such revision shall not change the F@rant element obtained under the above-mentioned repayment modification.

(c) if, at any time after a modification of terms pursuant to paragraph (b) above, the Association determines that the Borrower's economic condition has deteriorated significantly, the Association may, if so requested by the Borrower, further modify the terms of repayment to conform to the schedule of installments as provided in paragraph (a) above.

Section 2.08. The currency of the United Kingdom of Great Britain and Northern Ireland is hereby specified for the purposes of Section 4.02 of the General Conditions.

ARTICLE III

Execution of the Project

Section 3.01. (a) The Borrower declares its commitment to the objectives of the Project as set forth in Schedule 2 to this Agreement and, to this end, shall carry out Parts A.1 through A.4 of the Project through MCH, Part A.5 of the Project through the Planning Commission and Parts B and C of the Project through MLG, with due diligence and efficiency and in conformity with appropriate administrative, financial and public health practices, and shall provide, promptly as needed, the funds, facilities, services and other resources required for the Project.

(b) Without limitation upon the provisions of paragraph (a) of this Section and except as the Borrower and the Association shall otherwise agree, the Borrower shall carry out the Project in accordance with the Implementation Program set forth in Schedule 4 to this Agreement.

Section 3.02. Except as the Association shall otherwise agree, procurement of the goods, works and consultants' services required for the Project and to be financed out of the proceeds of the Credit shall be governed by the provisions of Schedule 3 to this Agreement.

Section 3.03. The Borrower shall by: (a) December 31, 1991, furnish to the Association on its review and comments, the draft health manpower plan under Part A of the Project; and (b) July 1, 1992 commence implementation of the health manpower plan taking the Association's comments into account.

Section 3.04. The Borrower shall by July 1, 1991: (a) increase the share of its recurrent budget allocated to the health sector to a level satisfactory to the Association; and (b) adopt an improved incentives package for health sector staff.

Section 3.05. The Borrower shall, by April 30, 1992, furnish to the Association for its review and comments, a plan of action for long-term financing of the health sector, and promptly thereafter commence implementation of such plan of action, taking the Association's comments into account.

Section 3.06. The Borrower shall, by July 1, 1992, review with the Association the study of the domestic pharmaceuticals industry under Part A of the Project and agree on a plan of action based on such review.

Section 3.07. The Borrower shall by May 31 in each year agree with the Association on adequate budgetary provision for the Project and ensure that these funds are allocated in a timely manner.

ARTICLE IV

Financial Covenants

Section 4.01. (a) The Borrower shall maintain or cause to be maintained records and accounts adequate to reflect in accordance with sound accounting practices the operations, resources and expenditures in respect of the Project of the departments or agencies of the Borrower responsible for carrying out the Project or any part thereof.

(b) The Borrower shall:

(i) have the records and accounts referred to in paragraph (a) of this Section including those for the Special Accounts for each fiscal year audited, in accordance with appropriate auditing principles consistently applied, by independent auditors acceptable to the Association;

(ii) furnish to the Association, as soon as available, but in any case not later than nine months after the end of each such year, a certified copy of the report of such audit by said auditors, of such scope and in such detail as the Association shall have reasonably requested; and

(ii) furnish to the Association such other information concerning said records, accounts and the audit thereof as the Association shall from time to time reasonably request.

(c) For all expenditures with respect to which withdrawals from the Credit Account were made on the basis of statements of expenditures, the Borrower shall:

(i) maintain or cause to be maintained, in accordance with paragraph (a) of this Section, records and accounts reflecting such expenditures;

(ii) retain, until at least one year after the Association has received the audit for the fiscal year in which the last withdrawal from the Credit Account was made, all records (contracts, orders, invoices, bills, receipts and other documents) evidencing such expenditures;

(iii) enable the Association's representatives to examine such records; and

(iv) ensure that such records and accounts are included in the annual audit referred to in paragraph (b) of this Section and that the report of such audit contains a separate opinion by said auditors as to whether the statements of expenditure submitted during such fiscal year, together with the procedures and internal controls involved in their preparation can be relied upon to support the related withdrawals.

ARTICLE V

Remedies of the Association

Section 5.01. Pursuant to Section 6.02 (h) of the General Conditions, the following additional events are specified:

(a) The Swiss Contribution Agreement shall have failed to become effective by June 30, 1991, or such later date as the Association may agree, provided, however, that the provisions of this paragraph shall not apply if the Borrower establishes to the satisfaction of the Association that adequate funds for the Project are available to the Borrower from other sources on terms and conditions consistent with the obligations of the Borrower under this Agreement.

(b) (i) Subject to subparagraph (ii) of this paragraph the right of the Borrower to withdraw the proceeds of the Swiss Contribution, DANIDA Grant, Belgian Grant or UNFPA Grant made to the Borrower for the financing of the Project shall have been suspended, cancelled or terminated in whole or in part, pursuant to the terms of the agreement providing therefor, or

(ii) Subparagraph (i) of this paragraph shall not apply if the Borrower establishes to the satisfaction of the Association that: (A) such suspension, cancellation, termination or prematuring is not caused

by the failure of the Borrower to perform any of its obligations under such agreement; and (B) adequate funds for the Project are available to the Borrower from other sources on terms and conditions consistent with the obligations of the Borrower under this Agreement.

ARTICLE VI

Termination

Section 6.01. The date ninety (90) days after the date of this Agreement is hereby specified for the purposes of Section 12.04 of the General Conditions.

ARTICLE VII

Representative of the Borrower; Addresses

Section 7.01. The Minister of the Borrower at the time responsible for finance is designated as representative of the Borrower for the purposes of Section 11.03 of the General Conditions.

Section 7.02. The following addresses are specified for the purposes of Section 11.01 of the General Conditions:

For the Borrower:

Ministry of Finance
P.O. Box 9111
Dar es Salaam
United Republic of Tanzania

Cable address:	Telex:
TREASURY Dar es Salaam	41329

For the Association:

International Development Association
1818 H Street, N.W.
Washington, D.C. 20433
United States of America

Cable address:	Telex:
INDEVAS Washington, D.C.	440098 (ITT) 248423 (RCA) or 64145 (WUI)

IN WITNESS WHEREOF, the parties hereto, acting through their duly authorized representatives, have caused this Agreement to be signed in their respective names in the District of Columbia, United States of America, as of the day and year first above written.

UNITED REPUBLIC OF TANZANIA

By /s/ Ali A. Karume
Authorized Representative

INTERNATIONAL DEVELOPMENT ASSOCIATION

By /s/ Edward V.K. Jaycox
Regional Vice President
Africa

SCHEDULE 1

Withdrawal of the Proceeds of the Credit

1. The table below sets forth the Categories of items to be financed out of the proceeds of the Credit, the allocation of the amounts of the Credit to each Category and the percentage of expenditures for items so to be financed in each Category:

Category	Amount of the Credit Allocated (Expressed in SDR Equivalent)	% of Expenditures to be Financed
(1) Part A of the Project:		
(a) Civil works:		100% of foreign expenditures and 85% of local expenditures
(i) for Part A.2 of the Project	760,000	
(ii) for Part A.3 of the Project	1,500,000	
(b) Vehicles, furniture, equipment and supplies	2,270,000	100% of foreign expenditures and 85% of local expenditures
(c) Consultants' services and training	1,290,000	100%
(d) Eligible travel and per them expenditures	110,000	100%
(e) Pharmaceuticals	21,190,000	100%
(f) Overseas training	200,000	100%
(2) Part B of the Project:		

(a)	Civil works	1,820,000	100% of foreign expenditures and 85% of local expenditures
(b)	Vehicles, furniture, equipment and supplies	4,390,000	100% of foreign expenditures and 85% of local expenditures
(c)	Consultants' services and training	530,000	100%
(d)	Eligible travel and per them expenditures	230,000	100%
(3)	Refunding of Project Preparation Advance	380,000	Amount due pursuant to Section 2.02 (c) of this Agreement
(4)	Unallocated	1,430,000	
	TOTAL	36,100,000	

2. For the purposes of this Schedule:

(a) the term "foreign expenditures" means expenditures in the currency of any country other than that of the Borrower for goods or services supplied from the territory of any country other than that of the Borrower;

(b) the term "local expenditures" means expenditures in the currency of the Borrower or for goods or services supplied from the territory of the Borrower; and

(c) "eligible travel and per them expenditures" means incremental travel and per them for activities under Parts A.1 (a), A.1 (b) and B of the Project.

3. Notwithstanding the provisions of paragraph 1 above, no withdrawals shall be made in respect of:

(a) payments made for expenditures prior to the date of this Agreement;

(b) payments made for expenditures under Category (1) (a) (ii) until the Borrower has adopted a revised institutional structure for CMS satisfactory to the Association and the Association is satisfied with the plan of action for the rehabilitation of CMS:

(c) payments made for expenditures incurred in any particular district from Categories (2) (a) through (2) (d), except payments for expenditures with respect to the Basic Package, until: (i) the Borrower has complied with the provisions of paragraph 4 (d) of Schedule 4 to this Agreement; and (ii) the Association has approved the district health plan for the district concerned; and

(d) payments Trade for expenditures under Category (1) (f) until the Borrower has complied with the provisions of paragraph 2 (c) of Schedule 4 to this Agreement.

4. (a) No withdrawal shall be made and no commitment shall be entered into to pay amounts to or on the order of the Borrower in respect of expenditures to be financed out of the proceeds of the Credit allocated to Category (1) (e) in the table in paragraph 1 above after the aggregate of the proceeds of the Credit withdrawn from the Credit Account for said Category (1) (e) and the total amount of such commitments shall have reached the equivalent of SDR 7,570,000 unless the Association shall be satisfied with the evidence furnished by the Borrower on the progress in the implementation of reforms in the pricing, financing and budgeting, and capacity-building in the procurement of pharmaceuticals; and (b) no further withdrawals shall be made and no commitment shall be entered into to pay amounts to or on the order of the Borrower in respect of expenditures to be financed out of the proceeds of the Credit allocated to Category (1) (e) in the table in paragraph 1 above after the aggregate proceeds of the Credit withdrawn from the Credit Account for said Category (1) (e) and the total amount of such commitments shall have reached the equivalent of SDR 14,380,000 unless the Association shall be satisfied with the evidence that the Borrower has commenced implementation of the resource mobilization measures for the health sector included in the plan of action referred to in Section 3.05 of this Agreement.

SCHEDULE 2

Description of the Project

The objectives of the Project are to support the Borrower's efforts to raise the quality, coverage and effectiveness of family planning, nutrition and basic health services in urban and rural areas.

The Project consists of the following parts, subject to such modifications thereof as the Borrower and the Association may agree upon from time to time to achieve such objectives:

Part A: Strengthening National PHN Systems

1. Health Planning, Policy Formulation and Information System

(a) Strengthening of the planning and policy formulation capability of MOH, through staff training and the acquisition of equipment and supplies for the Planning Department of MOH;

(b) carrying out policy oriented studies on the long-term financing options of the health sector and the financial and economic feasibility of the domestic pharmaceuticals industry;

(c) establishment and implementation of an integrated health information system at the central, regional and district levels, including acquisition of necessary computers, software and supplies, and the

training of staff; and

(d) strengthening Project Coordination in MOH.

2. Manpower Development and Training

(a) formulation of a manpower plan for the health sector;

(b) strengthening of DMDT through its reorganization including the addition of an inspectorate, the training of staff and acquisition of equipment and supplies;

(c) expansion of in-service training of health workers at the district level, including acquisition of equipment, teaching materials and transportation; and

(d) upgrading of five training schools to enable them to function as zonal training centers for the training of district health teams.

3. Pharmaceutical and Medical Supply System

(a) Acquisition and essential pharmaceuticals and medical supplies.

(b) reform of the pricing, financing, budgeting and procurement systems for pharmaceuticals and medical supplies;

(c) formulation of a master plan of CMS;

(d) rehabilitation of the CMS and strengthening of the CMS maintenance system through acquisition of supplies and training of maintenance staff based on the CMS master plan; and

(e) training of CMS staff in management and procurement.

4. Micro-Nutrient Deficiency Control Programs

Support to the Borrower's five-year programs to combat iron and Vitamin A deficiencies through training, promotion and production of iron and Vitamin A-rich foods, public education, laboratory development and support for research.

5. National Population Policy

Support for TCPD and its secretariat to oversee the implementation of the Borrower's National Population Policy, including the training of staff, acquisition of equipment and supplies, renovation of office space, research on population and the creation of a National Population Information Center.

Part B: Rural Primary Health Care

Implementation of the revised PHC Strategy in ten selected districts involving:

(1) community mobilization for PHC activities at the village level and support to village PHC initiatives, including, inter alia, nutrition programs, rehabilitation of health facilities and improved water supplies;

(2) strengthening of district PHC Systems based on District Health Plans, including training of the district management team in community mobilization, management planning and financial control, acquisition of vehicles for the DMOs and appropriate forms of transportation for other key staff, acquisition of supplies and furniture, rehabilitation of facilities and strengthening of maintenance services;

(3) strengthening of the District Health Referral System, including the rehabilitation of high priority facilities in five of the selected districts; and

(4) management, monitoring and evaluation of above activities by PSN.

Part C: Urban Primary Health Care

Implementation of a comprehensive program of urban PHC in the Dar es Salaam Region, focusing on:

(1) strengthening of PHC management and health information system in Dar es Salaam, including training of the Dar es Salaam City Medical Officer of Health and three DMOs in management, planning and financial control, the provision of office space and the acquisition of vehicles, equipment and supplies;

(2) strengthening of community participation and district PHC committees at village, ward and district level, through training of members in PHC strategy, acquisition of vehicles and support to urban community PHC initiatives;

(3) rehabilitation of the basic urban health network, including dispensaries, health centers and district hospitals in the Dar es Salaam area;

(4) establishment of an effective urban health maintenance system;

(5) construction of a limited number of PHC facilities in under-served areas of Dar es Salaam;

(6) acquisition of basic diagnostic equipment and medical supplies for all health facilities in Dar es Salaam; and

(7) carrying out of operations research on key health related areas, including nutritional interventions targeted to women and children in low-income households.

* * *

The Project is expected to be completed by December 31, 1995.

SCHEDULE 3

Procurement and Consultants' Services

Section I. Procurement of Goods and Works

Part A: International Competitive Bidding

1. Except as provided in Part D hereof, goods and works shall be procured under contracts awarded in accordance with procedures consistent with those set forth in Sections I and II of the "Guidelines for Procurement under IBRD Loans and IDA Credits" published by the Bank in May 1985 (the Guidelines).

2. To the extent practicable, contracts for civil works shall be grouped in bid packages estimated to cost the equivalent of $250,000 or more each.

Part B: Preference for Domestic Manufacturers

In the procurement of goods in accordance with the procedures described in Part A.1 hereof, goods manufactured in Tanzania may be granted a margin of preference in accordance with, and subject to, the provisions of paragraphs 2.55 and 2.56 of the Guidelines and paragraphs I through 4 of Appendix 2 thereto.

Part C: Preference for Domestic Contractors

In the procurement of works in accordance with the procedures described in Part A.1 hereof, the Borrower may grant a margin of preference to domestic contractors in accordance with, and subject to, the provisions of paragraphs 2.55 and 2.56 of the Guidelines and paragraph 5 of Appendix 2 thereto.

Part D: Other Procurement Procedures

1. Civil works for Part A of the Project estimated to cost less than the equivalent of $250,000 per contract, up to an aggregate amount not to exceed the equivalent of $2,000,000, and supplies estimated to cost less than $100,000 per contract, up to an aggregate amount not to exceed the equivalent of $800,000, may be procured under contracts awarded on the basis of competitive bidding advertised locally in accordance with procedures satisfactory to the Association.

2. Goods estimated to cost less than the equivalent of $100,000 per contract, up to an aggregate amount not to exceed the equivalent of $3,100,000, may be procured under contracts awarded on the basis of comparison of price quotations solicited from a list of at least three suppliers eligible under the Guidelines, in accordance with procedures acceptable to the Association.

3. Civil works under Part B of the Project, up to an aggregate amount not to exceed the equivalent of $400,000, may be carried out by force account in the Districts concerned.

Part E: Review by the Association of Procurement Decisions

1. Review of invitations to bid and of proposed awards

and final contracts:

(a) With respect to each contract estimated to cost the equivalent of $100,000 or more the procedures set forth in paragraphs 2 and 4 of Appendix 1 to the Guidelines shall apply. Where payments for such contract are to be made out of the Special Accounts, such procedures shall be modified to ensure that the two conformed copies of the contract required to be furnished to the Association pursuant to said paragraph 2 (d) shall be furnished to the Association prior to the making of the first payment out of the respective Special Account in respect of such contract.

(b) With respect to each contract not governed by the preceding paragraph, the procedures set forth in paragraphs 3 and 4 of Appendix 1 to the Guidelines shall apply. Where payments for such contract are to be made out of the Special Accounts, such procedures shall be modified to ensure that the two conformed copies of the contract together with the other information required to be furnished to the Association pursuant to said paragraph 3 shall be furnished to the Association as part of the evidence to be furnished pursuant to paragraph 4 of Schedule 5 to this Agreement.

2. The figure of 15% is hereby specified for purposes of paragraph 4 of Appendix 1 to the Guidelines.

Section II. Employment of Consultants

In order to assist the Borrower in carrying out the Project, the Borrower shall employ consultants whose qualifications, experience and terms and conditions of employment shall be satisfactory to the Association. Such consultants shall be selected in accordance with principles and procedures satisfactory to the Association on the basis of the "Guidelines for the Use of Consultants by World Bank Borrowers and by the World Bank as Executing Agency" published by the Bank in August 1981.

SCHEDULE 4

Implementation Program

Project Coordination

1. (a) In order to coordinate Project activities, the Borrower shall maintain until completion of the Project, a Project Coordination Committee, comprising representatives of MOH, MLG, MOF, the Planning Commission, TFNC and the Dar es Salaam City Council, and chaired by the Permanent Secretary of MOH. The PCC shall meet at least once every quarter to review progress in implementing the Project and resolve any outstanding issues.

(b) The Borrower and the Association shall by May 31, in each year undertake a comprehensive annual joint review of the Project.

2. Part A of the Project

(a) Part A of the Project shall be managed by MOH and a project coordinator from the MOH Planning Department shall coordinate Project implementation. He shall be assisted by an accountant and a procurement officer with qualifications satisfactory to the Association. The Project Coordinator shall liaise with the Planning Department for Part A.1, DMDT for Part A.2, CMS and the Department of Hospital Services for Part A.3 and TFNC for Part A.4.

(b) The Borrower shall by July 1, 1993, strengthen the MOH Planning Department by a net increase of six staff, filling the existing vacancies for a Public Health Specialist, Senior Economist, Senior Statistician, Epidemiologist, Health Economist and Economist.

(c) The Borrower shall adopt a plan of action for the strengthening of DMDT, satisfactory to the Association, which shall include, inter alia, the addition of an inspectorate, the timely appointment of suitably qualified staff to fill the positions of inspector and of head of the Basic Education (Allied Health) Unit, the clear delineation of responsibilities among staff for technical, logistic and administrative functions, and a timetable for upgrading staff skills to suit the DMDT's enhanced responsibilities.

(d) The Borrower shall ensure that candidates for external training under Part 2 (b) of the Project shall be selected in accordance with criteria satisfactory to the Association.

(e) TFNC shall coordinate the other agencies involved in the execution of the micro-nutrient deficiency control programs under Part A.4. The Borrower shall by December 31, 1992, undertake a mid-term evaluation of the programs, according to protocols acceptable to the Association, and review the results of the evaluation with the Association.

(f) The PHC Secretariat, reporting to the Chief Medical Officer shall be responsible for preparing and refining the PHC strategy.

3. Part B of the Project

(a) Part B of the Project shall be managed by MLC and a project coordinator from the Department of Local Government shall be responsible for management, monitoring and evaluation of Part B of the Project and shall head the PSN. He shall be assisted by an accountant and a procurement officer whose qualifications shall be satisfactory to the Association. The Borrower shall by December 31, 1990, appoint a community development specialist an@ assign a civil engineer from the Ministry of Works to PSN, all with qualifications satisfactory to the Association. The primary medical services unit within MOH shall be responsible for providing technical guidance to PSN and shall assign a public health specialist in the unit, on a full time basis to assist PSN in implementing Part B of the Project.

(b) Execution of Part B shall be the responsibility of the ten district governments. The DMO in each district

shall take overall responsibility for supervising implementation.

4. (a) The Borrower shall by December 31, 1990, agree with the Association on:

(i) the revised PHC Strategy;

(ii) guidelines for the rehabilitation of the district health referral system in the ten selected districts;

(iii) the list of criteria for evaluating the performance of districts under the Project; and

(iv) guidelines for the preparation of district health plans.

(b) The Borrower shall by November 30 in each year, for each of the ten selected districts furnish to the Association for its approval, the district health plans for the forthcoming year, developed in accordance with the agreed guidelines. During the first two years of Project implementation, as the ten districts will be in different stages of starting up, this provision shall be waived, although the Borrower shall still seek the Association's approval prior to the implementation of such plans.

(c) In order to facilitate the implementation of Part B of the Project, the Borrower shall maintain in each of the ten selected districts an account, to be called Account No. 6 through which funds for Part B of the Project will pass with the DMO as the first signatory.

(d) The Borrower shall, in each selected district, appoint an Officer in Charge of the district hospital, reporting to the DMO, thereby releasing the DMO from the day-to-day management of the hospital.

(e) The Borrower shall: (i) by June 30, 1991, agree with the Association on protocols to be used in evaluating the implementation of the revised PHC Strategy; and (ii) by December 31, 1992, undertake a mid-term evaluation of the implementation of the revised PHC strategy, according to such protocols acceptable to the Association, and review the results of such evaluation with the Association.

5. Part C of the Project

The Borrower shall implement Part C of the Project in accordance with the terms of the intergovernmental agreement referred to in paragraph B of the Preamble to this Agreement.

SCHEDULE 5

Special Accounts

1. For the purposes of this Schedule:

(a) the term "eligible Categories" means Category (1) (a) through (e) (for the MOH Special Account) and Category (2) (a) through (d) (for the MLG Special Account) set forth in the table in paragraph 1 of Schedule 1 to this Agreement;

(b) the term "eligible expenditures" means expenditures in respect of the reasonable cost of goods and services required for the Project and to be financed out of the proceeds of the Credit allocated from time to time to the eligible Categories in accordance with the provisions of Schedule 1 to this Agreement; and

(c) the term "Authorized Allocation" means an amount equivalent to $1,250,000 or the MOH Special Account and $750,000 for the MLG Special Account to be withdrawn from the Credit Account and deposited into the Special Accounts pursuant to paragraph 3 (a) of this Schedule.

2. Payments out of the Special Accounts shall be made exclusively for eligible expenditures in accordance with the provisions of this Schedule.

3. After the Association has received evidence satisfactory to it that the Special Accounts have been duly opened, withdrawals of the Authorized Allocation and subsequent withdrawals to replenish the Special Accounts shall be made as follows:

(a) For withdrawals of the Authorized Allocation, the Borrower shall furnish to the Association a request or requests for a deposit or deposits which do not exceed the aggregate amount of the Authorized Allocation. On the basis of such request or requests, the Association shall, on behalf of the Borrower, withdraw from the Credit Account and deposit into the respective Special Account such amount or amounts as the Borrower shall have requested.

(b) (i) For replenishment of the respective Special Account, the Borrower shall furnish to the Association requests for deposits into the Special Account at such intervals as the Association shall specify.

(ii) Prior to, or at the time of each such request, the Borrower shall furnish to the Association the documents and other evidence required pursuant to paragraph 4 of this Schedule for the payment or payments in respect of which replenishment is requested. On the basis of each such request, the Association shall, on behalf of the Borrower, withdraw from the Credit Account and deposit into the respective Special Accounts such amounts as the Borrower shall have requested and as shall have been shown by said documents and other evidence to have been paid out of the respective Special Accounts for eligible expenditures.

All such deposits shall be withdrawn by the Association

from the Credit Account under the respective eligible Categories, and in the respective equivalent amounts, as shall have been justified by said documents and other evidence.

4. For each payment made by the Borrower out of the Special Accounts, the Borrower shall, at such time as the Association shall reasonably request, furnish to the Association such documents and other evidence showing that such payment was made exclusively for eligible expenditures.

5. Notwithstanding the provisions of paragraph 3 of this Schedule, the Association shall not be required to make further deposits into the Special Accounts:

(a) if, at any time, the Association shall have determined that all further withdrawals should be made by the Borrower directly from the Credit Account in accordance with the provisions of Article V of the General Conditions and paragraph (a) of Section 2.02 of this Agreement; or

(b) once the total unwithdrawn amount of the Credit allocated to the eligible Categories, less the amount of any outstanding special commitment entered into by the Association pursuant to Section 5.02 of the General Conditions with respect to the Project, shall equal the equivalent of twice the amount of the Authorized Allocation.

Thereafter, withdrawal from the Credit Account of the remaining unwithdrawn amount of the Credit allocated to the eligible Categories shall follow such procedures as the Association shall specify by notice to the Borrower. Such further withdrawals shall be made only after and to the extent that the Association shall have been satisfied that all such amounts remaining on deposit in the respective Special Accounts as of the date of such notice will be utilized in making payments for eligible expenditures.

6. (a) If the Association shall have determined at any time that any payment out of the Special Accounts: (i) was made for an expenditure or in an amount not eligible pursuant to paragraph 2 of this Schedule; (ii) was not justified by the evidence furnished to the Association, the Borrower shall, promptly upon notice from the Association (A) provide such additional evidence as the Association may request, or (B) deposit into the respective Special Accounts (or, if the Association shall so request, refund to the Association) an amount equal to the amount of such payment or the portion thereof not so eligible or justified. Unless the Association shall otherwise agree, no further deposit by the Association into the respective Special Accounts shall be made until the Borrower has provided such evidence or made such deposit or refund, as the case may be.

(b) If the Association shall have determined at any time that any amount outstanding in the Special Accounts will not be required to cover further payments for eligible expenditures, the Borrower shall, promptly upon notice from the Association, refund to the Association

such outstanding amount.

(c) The Borrower may, upon notice to the Association, refund to the Association all or any portion of the funds on deposit in the Special Accounts.

(d) Refunds to the Association made pursuant to paragraph 6 (a), (b) and (c) of this Schedule shall be credited to the Credit Account for subsequent withdrawal or for cancellation in accordance with the relevant provisions of this Agreement, including the General Conditions.