

AFRICAN DEVELOPMENT FUND

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UNITED REPUBLIC OF TANZANIA

SUPPORT TO MATERNAL MORTALITY REDUCTION PROJECT

APPRAISAL REPORT

**HUMAN DEVELOPMENT DEPARTMENT
HEALTH DIVISION**

**OSHD.3
AUGUST 2006**

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This report was prepared by Mr. W. Muchenje, Chief Health Analyst, F. Mvula, Senior Architect, G. Geisler, Senior Gender Specialist and H. Hashi, Social Sector Specialist (TZFO), following their mission to Tanzania in June/July 2006. Inquiries should be addressed to Ms. A. Hamer, (Ext. 2046) Director, OSHD; Mr. T. Ilunga, Manager, OSHD.3 (Ext. 2117) or Mr. W. Muchenje, Chief Health Analyst, OSHD.3 (Ext 2443) and Mr. F. Mvula, OSHD.3 (Ext. 3688).

AFRICAN DEVELOPMENT BANK GROUP

01 BP 1387 Abidjan 01
Cote D'Ivoire
Tel: +225 2020 4444
Fax: + 225 2021 7753

BP 323, 1002
Tunis Belvedere, Tunisia
Tel: +216 71 335 511
Fax: +216 71 351 933

PROJECT INFORMATION SHEET

Date: July 2006

The information given hereunder is intended to provide some guidance to prospective suppliers, contractors, consultants and all persons interested in the procurement of goods and services for projects approved by the Board of Directors of the Bank Group. More detailed information and guidance should be obtained from the Executing Agency of the Borrower.

1. COUNTRY: United Republic of Tanzania
2. NAME OF PROJECT: Support to Maternal Mortality Reduction
3. LOCATION: Mara, Tabora, Mtwara and Zanzibar
4. BORROWER: United Republic of Tanzania
5. EXECUTING AGENCY: Ministry of Health and Social Welfare (Mainland)
Ministry of Health and Social Welfare (Zanzibar)
Tel: + 255 22 5120261 (Mainland)
Fax: + 255 22 110986 (Mainland)
Tel: + 255 24-2230189/91 (Zanzibar)
Fax: + 255 24-2235821 (Zanzibar)
6. PROJECT DESCRIPTION: The Project will consist of the following:
 - i) Component I – Strengthened Delivery of Maternal Health Services (Mainland)
 - ii) Component II – Strengthened Delivery of Health Care Services (Zanzibar)
 - iii) Component III – Management and Coordination.
7. TOTAL COST: UA million UA 44.44 million
 - i) Foreign Exchange UA 25.71 million
 - ii) Local Cost UA 18.73 million
8. BANK GROUP FINANCING
ADF (LOAN) UA 40.00 million
9. OTHER SOURCES OF FINANCE:
GOVERNMENT UA 4.44 million
10. ESTIMATED DATE OF APPROVAL: October 2006
11. ESTIMATED STARTING DATE AND DURATION: January 2007; 5 years

12. PROCUREMENT:

Procurement of goods and services would be undertaken in accordance with the following Bank Group's rules of procedure:

International Competitive Bidding (ICB): Biomedical Equipment for facilities (M), and Radio Communication Equipment.

National Competitive Bidding (NCB): Civil works for rehabilitation and extension of health facilities in the three regions on the mainland; rehabilitation and upgrading two training institutions in Tabora and Mtwara; extension of CHS in Zanzibar; upgrading of 2nd line dispensaries and construction of housing units in Zanzibar; refurbishment of PMU offices in Zanzibar; and erection of incinerators in Pemba; furniture and equipment for the CHS, PHC units and rehabilitated facilities (M), furniture and equipment for training institutions, furniture and equipment for CHS, furniture and equipment for 2nd line Dispensaries, and office equipment for (M) and (Z).

Short List (SL): Technical Assistance and Auditors, Consultant for supervision of civil works; PMU staff for Zanzibar.

Government Procedures: Training of health cadres and CHS staff; Scholarships for students, Zonal training in project management, workshops.

International Shopping: Ambulances

National Shopping (NS): Furniture and equipment for the PMU, vehicles, printing job aids,

13. CONSULTANCY SERVICES

Consultancy services will be required for annual auditing, College of Health Sciences curriculum review, College of Health Sciences business plan development, PHC training needs assessment, and supervision of civil works.

CURRENCY EQUIVALENT

	(July 2006)	
National Currency	:	Tanzania Shilling (T)
UA 1	=	TZS 1,878.18
UA 1	=	USD 1.47937

WEIGHTS AND MEASURES

Metric System

FISCAL YEAR

1 July to 30 June

LIST OF ABBREVIATIONS

ADB	African Development Bank
ADF	African Development Fund
AIDS	Acquired Immune Deficiency Syndrome
AMO	Assistant Medical Officer
ANC	Antenatal Care
BCC	Behaviour Change Communication
BOD	Burden of Disease
CBO	Community Based Organization
CHMT	Council Health Management Team
CHS	College of Health Sciences
CSP	Country Strategy Paper
DANIDA	Danish International Development Agency
DCI	Development Cooperation Ireland
DFID	Department for International Development
DHMT	District Health Management Team
DP	Direct Purchase
EmOC	Emergency Obstetric Care
EPI	Expanded Program on Immunization
FANC	Focused Antenatal Care
FBO	Faith Based Organizations
FHRP	First Health Rehabilitation Project
FP	Family Planning
GDP	Gross Domestic Product
GFATM	Global Fund for AIDS/TB/Malaria
GPN	General Procurement Notice
GOT	Government of the United Republic of Tanzania
GOZ	Government of Zanzibar
GTZ	Deutsche Gesellschaft fuer Technische Zusammenarbeit
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HPU	Health Planning Unit
HSR	Health Sector Reform
HSRSP	Health Sector Reforms Strategic Plan
HSSP	Health Sector Strategic Plan
ICB	International Competitive Bidding
IEC	Information Education and Communication
IMCI	Integrated Management of Childhood Illnesses
IMF	International Monetary Fund
IMR	Infant Mortality Rate
INSP	Interim National Strategic Plan
JAS	Joint Assistance Strategy
JICA	Japanese International Cooperation Agency
LCA	Local Currency Account
LOGS	List of Goods and Services
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
M ²	Square Metres
MMR	Maternal Mortality Ratio
MOHSW	Ministry of Health and Social Welfare
MTEF	Medium Term Expenditure Framework

NSGRP	National Strategy for Growth and Reduction of Poverty
NCB	National Competitive Bidding
NGO	Non-Governmental Organization
NS	National Shopping
OBYS	Obstetrics
PAC	Post Abortion Care
PHC	Primary Health Care
PID	Project Implementation Document
PMU	Project Management Unit
PMTCT	Prevention of Mother to Child Transmission
PMORALG	Prime Minister's Office for Regional Administration and Local Government
QPPR	Quarterly Project Progress Report
RAS	Regional Administrative Secretary
RFP	Request for Proposal
RHMT	Regional Health Management Team
RMO	Regional Medical Officer
SA	Special Account
SDC	Swiss Development Cooperation
SL	Short Listing
SWAps	Sector Wide Approaches
TA	Technical Assistance
TBA	Traditional Birth Attendants
TDHS	Tanzania Demographic & Health Survey
TFR	Total Fertility Rate
TOTs	Trainers of Trainers
TZFO	Tanzania Field Office
TZS	Tanzania Shilling
UA	Units of Account
UN	United Nations
UNDP	United Nations Development Program
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
URT	United Republic of Tanzania
USAID	United States Agency for International Development
USD	United States Dollar
WHO	World Health Organization
VCT	Voluntary Counseling and Testing
VIP	Ventilated Improved Latrine

EXECUTIVE SUMMARY

Project Background

1.1 The United Republic of Tanzania comprises the Mainland and the Island of Zanzibar with a population of 33,584,607 and 984,625(2002). The union government deals with matters related to Defense, Home Affairs, Foreign Affairs and a common currency administered by the Bank of Tanzania. Other cabinet functions such as health and education, are managed separately by the two governments in the Mainland and in Zanzibar. In April 1998 the Mainland identified areas in need of technical analysis to improve effectiveness of public expenditures in the health sector. In pursuit of this objective, it submitted in June 1998 a request to the Bank Group for a grant to finance a study whose objective was to identify major constraints to the provision of health services in the three under-served regions of Mara, Mtwara and Tabora. A similar study was undertaken in the Islands of Zanzibar after the Bank Group provided a grant of UA 0.91 million in December 1997 for the preparation of the Zanzibar Health Development Requirements Study.

1.2 The Three Regions Health Study has provided prioritized action plans which have been incorporated in to the Comprehensive Council Health Plans (CCHP). The CCHP form the basis for funding the District Councils when implementing the Health Sector Strategic Plan (HSSP) within the SWAps arrangement. A similar study was undertaken on the Islands of Zanzibar after the Bank Group provided a grant of UA 0.91 million in December 1997 for the preparation of the Zanzibar Health Development Requirements Study. Findings from the study were incorporated into the Zanzibar Health Sector Reform Strategic Plan (HSRSP) for 2002/3 – 2006/7. Updated information from these studies contributed to the formulation of the proposed project, in particular, the readily available drawings, bills of quantities and tender documents will expedite implementation of the project. The improvements to the facilities are also in line with the draft Road Map for reduction of maternal mortality in terms of providing basic and comprehensive EmOC.

1.3 The Demographic Health Survey (2004), the Poverty and Human Development Report (2005) and the Technical Review of District Health Services Delivery in Tanzania (2006) have shown improvements in some health indicators except maternal mortality ratio. Following extensive consultations with the Ministries of Health and Social Welfare in both Mainland and Zanzibar, PMORALG, Development Partners and other stakeholders, the Bank concurred with Government's proposal to support its efforts in addressing the issue of high maternal mortality. In this regard, the project focuses on rehabilitation of health facilities and reproductive health which are part of the priority activities in the HSSP. In line with the HSSP, the project will be implemented within a SWAps arrangement in order to support a single policy and expenditure programme, however, procurement of goods, works and services will be based on Bank Group procedures.

Sector Goal and Objectives of ADF's Contribution

The sector goal is to improve the health and well-being of Tanzanians. The objective of ADF's contribution is to accelerate the reduction of maternal and newborn deaths in Mara, Mtwara, Tabora and Zanzibar.

Brief Description of the Project

The Project will consist of the following three components:

- i) Component I – Strengthened Delivery of Maternal Health Services (Mainland)
- ii) Component II – Strengthened Delivery of Health Care Services (Zanzibar)
- iii) Component III - Management and Coordination.

Project Costs

The total Project cost, net of taxes and custom duties, is estimated at UA 44.44 million, of which UA 25.71 million (58%) is in foreign exchange and the equivalent of UA 18.73 million (42%) is in local currency.

Sources of Finance

The Project will be financed by the African Development Fund (UA 40.00 million), and Government of Tanzania (UA 4.44 million) equivalent to USD 65.75 million in total. ADF will finance goods and civil works, and partly finance services and operating costs. The Government of Tanzania's contribution of UA 4.44 million, representing 10% of the total Project costs, will partly finance civil works.

Project Implementation

Project implementation is expected to last 5 years (60 months) starting from January 2007. The implementation schedule is presented in *Annex V*. The Ministries of Health and Social Welfare in both Mainland and Zanzibar will be the Executing Agencies. The Programme Manager and professional staff will be recruited using the Bank Group's "Rules of Procedure for the Use of Consultants" following the procedure outlined therein for the recruitment of individual consultants for long-term assignments.

Conclusions and Recommendations

Factors underlying direct causes of maternal and newborn deaths operate at several levels and lack of access to and use of, essential obstetric services in particular is a crucial factor that is contributing to high maternal mortality. A significant reduction in newborn deaths can also be achieved with interventions designed to improve the health of the mother and her access to care during labour, birth, and the critical hours immediately afterwards. The project has been designed to scale-up appropriate maternal health care programmes by enhancing availability of skilled birth attendants and assuring pregnant women access to Emergency Obstetric Care (EmOC) in the event of obstetric complications. In addition, housing will be provided at the health centre level in Mainland and at the first line dispensaries in Zanzibar in order to ensure availability of staff in case of emergencies. This will also serve as an incentive toward retention of staff in rural areas.

The project is also expected to develop and implement a comprehensive training plan to ensure availability of staff at the right levels with the required competencies and in appropriate numbers to provide effective maternal health care. The institutional capacity of the CHS will be strengthened to enable it to increase its output in line with the country's needs and improve the quality of its tutors and trainees. Institutional strengthening will

include some physical expansion in line with the increased intake of students. Working closely with the World Health Organization and the Commonwealth Health Secretariat the teaching capacity at the College of Health Sciences in Zanzibar will be strengthened through recruitment of tutors from neighbouring countries.

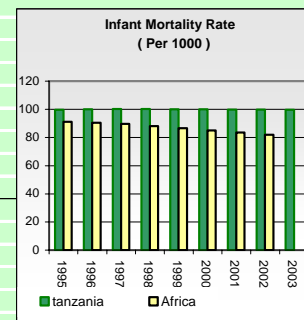
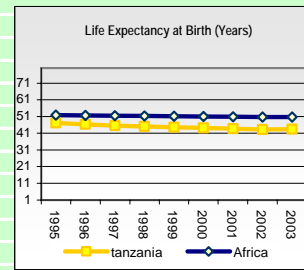
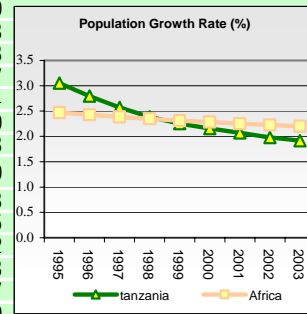
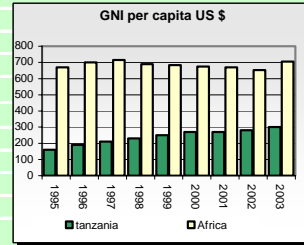
The Project will have significant health and socio-economic impacts, as a result of: improved access to quality health care for rural populations in line with equity principles contained in the health sector reforms; increased utilization of health facilities for uncomplicated deliveries; improved maternal health; reduced severity of illnesses such as malaria as a result of improved access to care and treatment. In addition, socio-economic impacts include: savings for rural people who will not have to travel far in search of better health care and gains in productivity as a result of averted maternal deaths and disabilities. The Project is expected to benefit women to a large extent and will contribute to addressing gender disparities in health and access to opportunities.

It is recommended that an ADF loan not exceeding UA 40.00 million be granted to the Government of the United Republic of Tanzania for the purpose of implementing the Project as described in this report.

Tanzania

COMPARATIVE SOCIO-ECONOMIC INDICATORS

	Year	Tanzania	Africa	Developing Countries	Developed Countries
Basic Indicators					
Area ('000 Km ²)		945	30 061	80 976	54 658
Total Population (millions)	2003	37.0	849.5	5,024.6	1,200.3
Urban Population (% of Total)	2003	35.3	39.2	43.1	78.0
Population Density (per Km ²)	2003	39.1	28.3	60.6	22.9
GNI per Capita (US \$)	2003	300	704	1 154	26 214
Labor Force Participation - Total (%)	2003	51.2	43.3	45.6	54.6
Labor Force Participation - Female (%)	2003	49.2	41.0	39.7	44.9
Gender -Related Development Index Value	2002	0.401	0.476	0.655	0.905
Human Develop. Index (Rank among 174 countries)	2002	162	n.a.	n.a.	n.a.
Popul. Living Below \$ 1 a Day (% of Population)	1993	19.9	46.7	23.0	20.0
Demographic Indicators					
Population Growth Rate - Total (%)	2003	1.9	2.2	1.7	0.6
Population Growth Rate - Urban (%)	2003	5.5	3.8	2.9	0.5
Population < 15 years (%)	2003	45.7	42.0	32.4	18.0
Population >= 65 years (%)	2003	2.4	3.3	5.1	14.3
Dependency Ratio (%)	2003	90.0	86.1	61.1	48.3
Sex Ratio (per 100 female)	2003	98.2	99.0	103.3	94.7
Female Population 15-49 years (% of total population)	2003	23.5	24.0	26.9	25.4
Life Expectancy at Birth - Total (years)	2003	43.4	50.7	62.0	78.0
Life Expectancy at Birth - Female (years)	2003	44.2	51.7	66.3	79.3
Crude Birth Rate (per 1,000)	2003	38.8	37.0	24.0	12.0
Crude Death Rate (per 1,000)	2003	18.0	15.2	8.4	10.3
Infant Mortality Rate (per 1,000)	2003	99.7	80.6	60.9	7.5
Child Mortality Rate (per 1,000)	2003	161.2	133.3	79.8	10.2
Maternal Mortality Rate (per 100,000)	1995	530	661	440	13
Total Fertility Rate (per woman)	2003	5.0	4.9	2.8	1.7
Women Using Contraception (%)	1999	25.4	40.0	59.0	74.0
Health & Nutrition Indicators					
Physicians (per 100,000 people)	1995	4.3	57.6	78.0	287.0
Nurses (per 100,000 people)	1987	17.7	105.8	98.0	782.0
Births attended by Trained Health Personnel (%)	1999	35.0	44.0	56.0	99.0
Access to Safe Water (% of Population)	2002	51.0	64.4	78.0	100.0
Access to Health Services (% of Population)	1991	93.0	61.7	80.0	100.0
Access to Sanitation (% of Population)	2000	90.0	42.6	52.0	100.0
Percent. of Adults (aged 15-49) Living with HIV/AIDS	2003	9.3	6.4	1.3	0.3
Incidence of Tuberculosis (per 100,000)	2000	155.0	109.7	144.0	11.0
Child Immunization Against Tuberculosis (%)	2003	91.0	81.0	82.0	93.0
Child Immunization Against Measles (%)	2003	72.0	71.7	73.0	90.0
Underweight Children (% of children under 5 years)	1999	29.4	25.9	31.0	...
Daily Calorie Supply per Capita	2002	1 975	2 444	2 675	3 285
Public Expenditure on Health (as % of GDP)	1998	1.3	3.3	1.8	6.3
Education Indicators					
Gross Enrolment Ratio (%)					
Primary School - Total	2001	70.0	88.7	91.0	102.3
Primary School - Female	2001	69.0	80.3	105.0	102.0
Secondary School - Total	2000	36.0	42.9	88.0	99.5
Secondary School - Female	2000	4.9	41.3	45.8	100.8
Primary School Female Teaching Staff (% of Total)	1997	43.7	46.3	51.0	82.0
Adult Illiteracy Rate - Total (%)	2003	21.9	36.9	26.6	1.2
Adult Illiteracy Rate - Male (%)	2002	14.8	28.4	19.0	0.8
Adult Illiteracy Rate - Female (%)	2003	29.4	45.2	34.2	1.6
Percentage of GDP Spent on Education	1998	5.8	5.7	3.9	5.9
Environmental Indicators					
Land Use (Arable Land as % of Total Land Area)	2003	4.2	6.2	9.9	11.6
Annual Rate of Deforestation (%)	1995	1.0	0.7	0.4	-0.2
Annual Rate of Reforestation (%)	1990	8.0	10.9
Per Capita CO2 Emissions (metric tons)	1998	0.1	1.2	1.9	12.3



Source : Compiled by the Statistics Division from ADB databases; UNAIDS; World Bank Live Database and United Nations Population Division.

Notes: n.a. Not Applicable ; ... Data Not Available.

RESULTS BASED PROJECT MATRIX

HIERARCHY OF OBJECTIVES	EXPECTED RESULTS	REACH	PERFORMANCE INDICATORS (SOURCE METHODS)	INDICATIVE TARGETS AND TIME FRAMES	ASSUMPTIONS/RISKS
Sector Goal To improve the health and well-being of Tanzanians.	Longer Term Outcome An improvement in health longevity among Tanzanians	Whole country.	Average life expectancy <u>Source</u> (Demographic & Health Surveys)	By year 2015 Tanzania average life expectancy increased by 2 year from 43 – 45. Reduction in maternal deaths from 578 per 100 000 live births to 265 Infant mortality rate reduced from 95 per 1000 live births to 50	
Project Objective The project objective is to accelerate the reduction of maternal and newborn deaths in Mara, Mtwara, Tabora and Zanzibar.	Medium Term Outcomes Reduction in maternal and neonatal morbidity and mortality	Communities in the three regions of Mara, Mtwara, Tabora and the Island of Zanzibar.	<ul style="list-style-type: none"> • Percentage of births attended by skilled health personnel • Percentage of home deliveries <u>Sources</u> <ul style="list-style-type: none"> • MOH statistical abstract 	By year 2011 <ul style="list-style-type: none"> • Increase in births attended by skilled personnel from 46% to 60% • Reduce home deliveries from 53% to 40%. 	Assumption Commitment by GOT to implementation of its Health Policy and National Road Map Action Plan to Accelerate the Reduction of Maternal and Newborn Death 2006-2010 <u>Risk indicators</u> Low
Activities/Inputs <u>Component I. Strengthened Delivery of Maternal Health Care Services (Mainland)</u> <ul style="list-style-type: none"> • Rehabilitation of selected hospitals health centres and dispensaries • Construction of new MCH units at selected dispensaries • Construction of new OBYS theatre at all health centres • Construction of staff houses at health centres • Procure biomedical equipment and furniture for selected health facilities. • Procure and install radio equipment in all health facilities. 	Short Term Outputs i). Improved access to emergency obstetric care (Mainland).	Communities and health personnel in the three regions of Mara, Mtwara, Tabora.	Number of health facilities rehabilitated. <ul style="list-style-type: none"> • Number of selected facilities rehabilitated. • Number of new MCH units at selected dispensaries constructed. • Number of new OBYS theatre at all health centres constructed. • Number of staff houses constructed • Proportion of adequately equipped health facilities for EMOC. • Proportion of facilities with Radio equipment installed • Number of ambulances 	Between 2007 and 2011 <ul style="list-style-type: none"> • 36 dispensaries, 8 health centres and 3 district hospitals rehabilitated • MCH units constructed in 104 dispensaries, • OBSY theatre constructed in 36 health centres and 10 hospitals • All 352 dispensaries, 36 health centers and 10 district hospitals will provided with some biomedical equipment and furniture. • All 352 dispensaries, 36 health centers and 10 district hospitals will provided radio equip. 	Assumption All Regions ensure participation of their representatives in all the process <u>Risk Indicators</u> Low All regions meet their commitments to implement new policies, protocols and guidelines. Risk indicators Low

HIERARCHY OF OBJECTIVES	EXPECTED RESULTS	REACH	PERFORMANCE INDICATORS (SOURCE METHODS)	INDICATIVE TARGETS AND TIME FRAMES	ASSUMPTIONS/RISKS
<ul style="list-style-type: none"> Procure ambulances for selected hospitals Conduct Zonal training on maintenance. Orientation of RHMTs and CHMTs on evidence based planning of MCH intervention Update and distribute job Aids on management of obstetric care Training TOTs to train community resource persons Train health workers in life saving skills, FANC, PAC and FP. Rehabilitate and expand selected training institutes Provide teaching and learning materials, equipment and furniture for training institutes Training of tutors 	<ul style="list-style-type: none"> ii) Increased skills in maternal health care. iii) Expand training institutions 	<p>Communities and health personnel in the three regions of Mara, Mtwara, Tabora.</p>	<p>procured</p> <ul style="list-style-type: none"> Number of trainings conducted. <p><u>Source:</u> QPPR</p> <p>Number of RHMTs and CHMTs on MCH interventions undertaken.</p> <p>Number of Job Aids updated and distributed.</p> <p>Number of TOTs and community resource persons trained</p> <p>Number of health workers trained in life saving skills, FANC, PAC and FP.</p> <p>Number of training institutes rehabilitated.</p> <p>Number of tutors trained.</p> <p>Number of training institutions expanded.</p>	<ul style="list-style-type: none"> An ambulance procured for each of the 8 districts. 36 staff houses constructed at health centres 3 zonal training on maintenance undertaken 3 RHMTs and 17 CHMTs oriented in MCH interventions. 1200 Job Aids updated and distributed. 34 TOTs (2 per district) and 800 Community resource persons identified and trained. 300 health workers trained in LSS, 600 health workers trained in FANC, 120 trained in PAC and 450 trained in Family Planning. 352 health workers (1 per facility) trained in community mobilization. 2 Training institutes rehabilitated & expanded 15 tutors trained. 2 Training facilities at Mara and Tabora expanded. 	<p><u>Assumption</u> GOT to recruit all the trained staff.</p> <p><u>Risk</u> Low</p> <p><u>Mitigating Measures</u> GOT to ensure that positions in the establishment are created according to staffing norms.</p> <p><u>Assumption</u> Communities' commitment to participating in training.</p> <p><u>Risk Indicator</u> Low</p> <p><u>Mitigating Measures</u> Involvement of local authorities in the design and management of the project.</p>
<p><u>Component II: Strengthened Delivery of Health Care Services (Zanzibar)</u></p> <ul style="list-style-type: none"> Extend College of Health Sciences Provide furniture and equipment for CHS. Upgrade selected 2nd line dispensaries. Procure furniture and equipment for 2nd line 	<p>iii) Strengthened Delivery of Health Care Services (Zanzibar)</p>	<p>Communities and health personnel in Zanzibar.</p>	<ul style="list-style-type: none"> College of Health Sciences extended Type of furniture supplied for college of health services Number of personnel of various cadres trained. Number of staff houses furnished Number of 2nd line dispensaries upgraded, 	<p>Two academic blocks, 2 dormitories and 2 blocks of staff houses constructed at CHS.</p> <p>40 staff houses build and furnished.</p> <p>100 and 450 PHC staff trained in emerging health problems and community participation respectively</p> <p>Six 2nd line dispensaries</p>	

HIERARCHY OF OBJECTIVES	EXPECTED RESULTS	REACH	PERFORMANCE INDICATORS (SOURCE METHODS)	INDICATIVE TARGETS AND TIME FRAMES	ASSUMPTIONS/RISKS										
dispensaries <ul style="list-style-type: none"> • Training of health cadres • Training of CHS staff • Construct staff houses at selected dispensaries. • Recruit TA tutors for CHS 			equipped & furnished. <ul style="list-style-type: none"> • Number of CHS staff trained • Number of TA tutors recruited 	upgraded, equipped and furnished 50 clinical officers, 10 AMOs, 10 ADOs, 5 Planning Officers, 5 professional and 5 technicians in from maintenance unit trained 15 tutors and 3 non academic staff from CHS trained. 15 staff from CHS attend short courses 4 TA tutors for CHS recruited.											
<p>Component III: Strengthened Management and Coordination</p> <p>Coordinate and manage project activities</p> <p>INPUTS ADF Loan 40 mill. UA GOT contribution 4.4. mill. UA</p> <p><u>Financing Plan</u> Source: Amount in UA ADF Loan 40 million (90%) GOT 4.44 million (10%)</p> <p><u>Project Cost by Category</u></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Category</th> <th style="text-align: right;">UA (mill)</th> </tr> </thead> <tbody> <tr> <td>A. Goods</td> <td style="text-align: right;">6.80</td> </tr> <tr> <td>B. Works</td> <td style="text-align: right;">29.94</td> </tr> <tr> <td>C. Services</td> <td style="text-align: right;">6.55</td> </tr> <tr> <td>D. Oper. Costs</td> <td style="text-align: right;">1.16</td> </tr> </tbody> </table>	Category	UA (mill)	A. Goods	6.80	B. Works	29.94	C. Services	6.55	D. Oper. Costs	1.16	<p>iv) <u>Management and Coordination</u></p> <p>Project Coordination Team in place at MOH & SW (Mainland)</p>	<p>All project beneficiaries and target population in the three regions</p>	<p>Loan agreement signed and made effective</p> <p>Source: MOH & SW – Director Policy Planning QPPR</p>	<p>Project</p>	<p>Assumptions as above</p>
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1. ORIGIN AND HISTORY OF THE PROJECT

1.1 The United Republic of Tanzania comprises the Mainland and the Island of Zanzibar with a population of 33,584,607 and 984,625(2002). The union government deals with matters related to Defense, Home Affairs, Foreign Affairs and a common currency administered by the Bank of Tanzania. Other cabinet functions such as health and education, are managed separately by the two governments in the Mainland and in Zanzibar. In April 1998 the Mainland identified areas in need of technical analysis to improve effectiveness of public expenditures in the health sector. In pursuit of this objective, it submitted in June 1998 a request to the Bank Group for a grant to finance a study whose objective was to identify major constraints to the provision of health services in the three under-served regions of Mara, Mtwara and Tabora. A similar study was undertaken in the Islands of Zanzibar after the Bank Group provided a grant of UA 0.91 million in December 1997 for the preparation of the Zanzibar Health Development Requirements Study.

1.2 The recently completed Three Regions Health Study and updated results from the Zanzibar Health Development Requirements Study have provided a substantial amount of information which has identified a number of structural and systemic problems impacting negatively on health service delivery at the district level. In February 2006, Government submitted a request to the Bank Group to fund a project proposal which includes some of the activities prepared under the two studies. The main theme of the proposal was reduction of maternal mortality. Government's proposal was based on evidence from the Demographic Health Survey (2004-5), the Poverty and Human Development Report (2005), the Technical Review of District Health Services Delivery in Tanzania (2006) and the Joint Country Analysis (2006) which all emphasized the urgent need to address the issue of high maternal mortality. Government's proposal focused on the three regions and Zanzibar given the fact that the two studies contain valuable information such as drawings and tender documents adequate for immediate project implementation.

1.3 The Bank undertook a preparation mission in April 2006 to hold extensive consultations with Ministries of Health and Social Welfare in Mainland and Zanzibar, the Prime Minister's Office for Regional Administration and Local Government (PMORALG), Development Partners and other stakeholders. The project was appraised in June/July 2006. Representatives from the Ministries of Health in Mainland and Zanzibar, PMORALG, Council Health Management Teams and other stakeholders participated in workshops which designed the project. ADF will support priority activities in the Health Sector Strategic Plan within the SWAps arrangement; however, procurement of goods, works and services will be based on Bank Group procedures. The project is in line with the draft Joint Assistance Strategy for Tanzania, Bank Group's updated Country Strategy Paper (2006), Government's effort to meet MDGs and the NSGRP (2005) which seeks to improve survival, health and well-being of all children, women and vulnerable groups.

2. THE HEALTH AND SOCIAL WELFARE SECTOR

2.1 Health Status

2.1.1 Mainland Tanzania has in recent years, experienced some significant improvements in the provision of health care services. It has for example, achieved a high coverage of antenatal care and immunization rate which is 94% (2004) and over 80% (2004) respectively. Infant mortality declined from 95 per 1,000 live births in 2002 to 68 per 1,000 live births in 2005, while the under five mortality rate decreased from 154 per 1,000 live births in 2002 to 122 per 1,000 live births in 2005. Notwithstanding these notable gains, about 90% of child deaths are due to preventable diseases such as malaria, pneumonia, diarrhoea, malnutrition and complications of low birth weight. Furthermore, HIV/AIDS, increasing incidence of drug resistant strains of malaria and high

maternal mortality have combined to undermine the health status of a considerable proportion of the Tanzanian population.

2.1.2 Malaria is the leading cause of outpatient morbidity and inpatient mortality in all age groups. It accounts for 48% and 26% of deaths among children under 5 years of age and in the population over 5 years of age respectively. The effects of malaria are more significant on children under 5 years of age and pregnant women. It is a major contributor to still births, low birth weight and neonatal mortality. HIV/AIDS is the second leading cause of death among adults, while among children under five years of age it is anemia. The HIV/AIDS pandemic, with 7.8 % of the total population infected, has affected women disproportionately due to higher infection rates at earlier ages, and increased workload through home based care. While the prominence of HIV/AIDS as a leading cause of mortality has increased over the last ten years, death due to Tuberculosis (TB) has declined from 14% in 2000 to 6% in 2004.

2.1.3 Although there has been some significant improvement on most health indicators over the last five years, maternal mortality ratio (MMR) has remained stagnant at 578/100,000 live births (2004). Nearly 9,000 women in Tanzania die annually due to pregnancy related causes (HSSP 2003). The leading causes of maternal mortality in both Mainland and Zanzibar are hemorrhage (ante-partum and post-partum), anemia and eclampsia mainly due to poor access to emergency obstetric services. Further, the poor quality of care, exemplified by shortage of qualified staff, low staff morale, lack of quality control and patient management, is contributing to the low rate of deliveries at health facilities, resulting in high MMR. Recent data from the Demographic and Health Survey demonstrate that the rate of caesarean sections in the country is also low indicating that Tanzanian mothers have insufficient access to essential maternal health services and specifically services for complicated deliveries.

2.2 Health Policy and Strategies

2.2.1 The vision of the Health Policy (2003) is to improve the health and well being of all Tanzanians with a focus on those most at risk, and encourage the health system to be more responsive to the needs of the people. The Health Sector Strategic Plan (HSSP) for Mainland Tanzania (2003/08) is a broad strategic plan intended to provide an enabling environment for implementing the national health policy. It focuses on the provision of quality health services by devolving direct day-to-day management control to the district and regional authorities. The HSSP has nine strategies which are integrated into three components namely: (i) the District Health Services, (ii) the Secondary and Tertiary Hospitals and other tertiary level institutions; and (iii) the Central Level which includes the role of the region as well as the Central Ministries.

2.2.2 The Mainland HSSP places more emphasis on district health services where most of the essential services are provided close to the communities. The Zanzibar Health Sector Reforms Strategic Plan (2002/3-2006/7) aims at improving the health and well-being of the people of Zanzibar with particular attention to women, children and vulnerable groups. The Strategic Plan is designed to ensure provision of preventive, curative and rehabilitative services, with a focus on the reduction of morbidity and mortality from all major causes of ill-health and the disparities therein. The reform initiatives have had a positive impact on the health system of both Mainland and Zanzibar.

2.2.3 On Mainland, the role of the Ministry of Health has been transformed to assume policy making responsibilities, while decision making power has been devolved to Council Health Management Teams (CHMTs). The Health Sector Reform Secretariat is working closely with PMORALG on issues regarding the implementation of the Local Government Reform at various levels. At regional level, the Regional Secretariat supports the delivery of health services through

Regional Health Management Teams, assesses Council Health Plans, ensures community participation in the management of health facilities through Health Service Boards and undertakes major rehabilitation of district hospitals and primary health care facilities. Outputs, targets and indicators of the HSSP are formulated in a matrix framework to allow periodic and annual review. The indicators are consistent with the MDGs.

2.2.4 The HSSP does not have a fully costed work programme, it is however, implemented through the Medium Term Expenditure Frameworks of the MOHSW and PMORALG. It is financed by domestic and foreign resources. A SWAps arrangement allowing for different funding modalities has been adopted with the view to ensuring that all available financial resources to the sector support a single policy and expenditure framework. The HSSP is monitored on a semi-annual basis through the SWAps Steering Committee. This committee facilitates effective coordination of the Health Sector and the Local Government Reforms. Some of the Local Government Reform coordination mechanisms such as Quarterly Meetings on which the MOH is represented will assist to strengthen coordination and synchronization of planning and implementation of the HSSP.

2.3 Organization of Health Services

2.3.1 In line with the policy on decentralization, the MOHSW (Mainland) and the PMORALG are jointly responsible for the provision of public health care services. The Minister of Health and Social Welfare is the head of the MOHSW and is assisted by a Deputy Minister, a Permanent Secretary and a Director General – Health Services. The health care delivery system is pyramidal in structure consisting of primary, secondary and tertiary levels. The primary level comprises dispensaries and health centres which form the entry point to the health care system for almost 80% of the population. There are 4,679 dispensaries throughout the country each serving a population of 6,000-10,000 people. In addition there are 481 health centres each serving a population of 50,000 and providing support and referral facilities to dispensaries.

2.3.2 The secondary level, which serves as a referral point for primary health care facilities, consists of district and regional hospitals. There are a total of 219 hospitals including district, regional and consultant hospitals which provide both inpatient and outpatient services. The 21 regional hospitals correspond to the 21 administrative regions in the Mainland. Tertiary care is provided at Muhimbili National Hospital, Kilimanjaro Christian Medical Centre, Moshi, Bugando Medical Centre and Mbeya Referral Hospital as well as by the following four specialized hospitals i.e. Ocean Road Cancer Institute, Muhimbili Orthopaedic Institute, Mirembe Psychiatry Hospital and Kibongoto Tuberculosis Hospital.

2.3.3 Mainland has 763 health facilities owned by voluntary agencies, 145 by parastatals while 733 are privately owned. This constitutes 17.7%, 3.0% and 15.0% respectively of the total number of health facilities in the Mainland. In some districts, faith based facilities receive public grants to support the provision of the essential health package, especially those designated as district hospitals in places with no government hospitals. Both the faith based organizations and other NGOs provide a mix of preventive and curative services especially in the rural areas. Private for-profit providers mainly play a curative role. Furthermore, some companies and industries provide health services to their employees and families. Traditional healers also provide health services, but the extent of their participation in the sector has not been documented.

2.3.4 In Zanzibar, the Minister of Health and Social Welfare is the political head of the Ministry, assisted by a Deputy Minister. The chief executive in charge of planning and administration is the Principal Secretary assisted by a Deputy Principal Secretary. There are also seven directorates as well as the chief government pharmacist, the Director of Mnazi Moja Hospital and the Health

Coordinator Pemba. In accordance with the Zanzibar Health Sector Reforms, health services management is decentralized to district level. There are ten districts, six of which are in Unguja. Health care services are provided at three levels namely, primary, secondary and tertiary. Providers of primary health care services in the public sector include 1st and 2nd line dispensaries or PHC units, and PHC centers or cottage hospitals. Secondary level care is provided at district hospitals. Tertiary and specialized care is provided at the Mnazi Moja National Referral Hospital and at the Maternity and Mental Hospitals, both of which are located in Unguja.

2.3.5 Zanzibar has a total of 227 health facilities of which 78 are private. Fifty three percent of the private health facilities are located in urban areas. Only three of the private health facilities are hospitals with in-patient facilities while the remainder, are dispensaries providing comprehensive PHC services including basic laboratory services. A 2004 situation analysis of the private health sector found that private health facilities had much better infrastructure than the public sector as well as better-qualified staff. While in-patient facilities were found to be under-utilized with a bed occupancy rate of only 17%, out patient facilities were found to contribute significantly to the reduction in overcrowding at public hospitals. While private health facilities provide outpatient and inpatient curative services and a wide range of PHC services they don't provide MCH services. As in the Mainland, there is no data on the extent of the traditional health sector, although it is generally agreed that a substantial proportion of the population utilizes the services of traditional healers.

2.4 Human Resources for Health

2.4.1 The health sector in the Mainland has a staff complement of 48,508, 72.4% are in the public sector; 20.3% are in the faith based health facilities and 7.3% work for the private for profit facilities. Women make up 58.3% of the health employees clustered among registered nurses (78%) and enrolled nurses (87.7%), whereas 86% of medical specialists are men. In addition the provider to population ratios is 1:5,000 for nurses, 1:14,000 for clinical officer and 1:138,000 for medical doctor. The Mainland is estimated to have a shortage of 20,000 skilled health personnel. The Zanzibar, health sector has a staff complement of 3,250 including support staff. This complement encompasses 39 medical doctors (1: 16,392), 343 nurses (1: 1,377); and a number of allied health professionals and auxiliaries. A situation analysis of health personnel in Zanzibar conducted in 2003 revealed acute shortages as well as imbalances in the distribution of health workers skewed towards urban areas and tertiary level facilities.

2.4.2 Tanzania, like other countries in the region, has experienced a large number of health workers migrating from rural to urban facilities as well as brain drain within and outside Africa. In Zanzibar, health workers have a tendency of migrating to the Mainland, and those posted to Pemba tend to leave for Unguja. The working environment is not conducive, as a lot of the infrastructure is in a state of disrepair, and equipment is malfunctioning or is non-existent. There are also limited opportunities for training and professional development for staff. In Pemba, it is particularly evident that lack of staff housing at PHC level contributes to Government's inability to retain staff.

2.4.3 *Mainland* has approximately 105 nursing and allied health-training institutions. Of these, Government owns 70 whereas 35 are owned by religious organizations. The majority of these institutions train nurses at certificate and diploma levels. In Zanzibar, the College of Health Sciences (CHS) is the only local training institution for health professionals. About 30% of the academic posts at CHS are vacant and its output is not sufficient to meet current and future staffing requirements for the MOHSW.

2.5 Financing of the Health Sector

2.5.1 The health sector in Mainland Tanzania is financed through government revenue including external resources originating from general budget support; the basket fund; and other external resources disbursed through government and donor specific mechanisms such as projects/programmes as well as domestic extra-budgetary resources i.e. user fees and payments into the Community Health Fund. As shown in Table 2.1 below, total public expenditure on health in terms of budget and actual expenditure and as a share of GDP has been increasing gradually over the years. The health budget, as a proportion of GDP, has fallen from 3% in 1999/2000 to 2.1% in 2003. The health sector share of the national budget is on the increase after declines in 2002/3 and 2003/4 from 11% in 2001/2. However, at 10.1% in 2004/5, it still falls short of the Abuja declaration target of 15%.

Table 2.1
Total Health Expenditure in Fiscal Years 2002 - 2005 (In Tshs Billion)

Budget Item	2001/2002		2002/2003		2003/2004		2004/2005
	Budget	Actual	Budget	Actual	Budget	Actual	Budget
Recurrent	123.89	117.15	154.60	143.14	172.28	173.31	241.04
Development	36.12	23.86	40.80	33.21	48.12	46.79	71.77
Total on Budget	160.01	141.01	195.4	176.36	220.40	220.1	312.81
Off Budget*	66.14	80.61	49.25	60.77	70.66	90.27	140.33
Grand Total	226.16	221.62	244.66	237.13	291.06	310.37	453.15
Health Expenditure as % age of GDP	1.6%		1.9%		1.9%		2.3%
Health Expenditure as % of total budget	11%		10.4%		9.7%		10.1%

Source: Ministry of Health and Social Welfare (Mainland)

2.5.2 Most of the recurrent budget is covered by government and most of the capital budget is covered by development partners. The additional resources generated from user fees are retained locally and supplement the resources local government dedicates to the provision of healthcare. User fees are charged at all public hospitals, health centres and dispensaries, however, there are waiver schemes meant to protect the vulnerable people. In Zanzibar, the health care system is largely financed through government revenue, and to a lesser extent external aid. The state of public finances is a major challenge to the authorities given the growing budget deficits over the past few years. Since the mid-1990s, total (recurrent plus development) MOHSW expenditures have averaged approximately 8% of the total expenditure, up from 7% in the early part of the last decade.

2.6 Major Problems in the Health Sector

2.6.1 Both Mainland and Zanzibar are experiencing critical shortages of skilled health workers. Many facilities are unable to provide quality care and have low utilization rates due to shortages of skilled health workers. Medical attendants, who are marginally skilled, are in most cases substituting for professional nurses and the current output of qualified staff from training institutions is inadequate to meet the staffing norms. In both Mainland and Zanzibar, the shortage of staff housing at or close to health facilities is a major contributing factor impeding recruitment and retention of qualified health workers in the rural areas. In Zanzibar in particular, the staff shortage has led to a situation where even if facilities are rehabilitated and equipment is there, deliveries cannot take place because trained staff is lacking.

2.6.2 Although Tanzania has a fair distribution of health facilities with over 75% of the total population living within 5 kilometres from a health facility, the increasing shortfall in the level of resources for maintenance has resulted in their physical deterioration. A recent assessment of primary health care facilities in Mara, Mtwara and Tabora Regions revealed that significant proportion are in need of repair, rehabilitation and replacement of basic capital equipment essential for effective provision of quality health care. The poor quality of some of the health facilities is also contributing to their underutilization. This is particularly true of deliveries where less than 50% are facility based and yet over 90% of the pregnant women attend ANC clinics. Few districts have established adequate referral mechanisms with corresponding information, communication, logistics, and managerial and technical support.

2.6.3 As indicated in paragraph 2.1.3 above, high MMR continues to be an area of major concern in Tanzania. The major problems in reducing MMR are (i) lack of skilled attendance during labour/delivery; (ii) accessing Emergency Obstetric Care (EmOC) in the event of obstetric complications and (iii) supportive environment in which skilled attendants can perform effectively. There is, therefore, need to strengthen service delivery capacity at the primary level, including human resources and infrastructure development, as well as greater involvement of communities and men in particular, in the planning of and making provisions for facility based deliveries.

2.7 Donor Support to the Health Sector

2.7.1 The 23 Development Partners shown in Table 2.2 are supporting the health sector on the Mainland using different funding modalities under SWAp arrangements. This includes general budget support, basket funding and donor-specific procedures integrated in the health sector programme and in the sector's MTEF. DFID is the only major development partner currently supporting the health sector through general budget support. A few more development partners are expected to move in due course to general budget support in line with the Ministry of Finance's preferred funding modality under the Joint Assistance Strategy. There are seven development partners (DCI, DANIDA, WB, Kfw, GTZ, Royal Netherlands Embassy, and SDC) channelling all or part of their contributions to the health sector through basket funding, and the rest like ADF and USAID constrained by their rules and regulations are supporting specific activities within the HSSP.

Table 2.2
 Health Sector Partners' Commitments/Projections 2006/07 – 2008/09 as per Public Expenditure
 Review 2005/06 (TZS)

Donor	2006/2007	2007/2008	2008/2009
ADF	4,211,324,000	3,937,704,000	
IDA	25,764,083,430	24,956,800,000	
WHO	674,739,750	683,476,000	
UNICEF	2,333,591,625		
UNFPA	1,008,851,836		
UNDP	408,959,483		
DENMARK	26,488,201,877	22,198,887,966	21,415,100,567
NORWAY	5,776,463,000	4,998,287,000	3,853,663,000
SDC	8,356,744,690	6,128,279,439	
SWEDEN	7,376,345,000		
DFID	4,352,106,000	5,009,600,000	
GERMANY/GTZ	3,490,994,000	3,400,175,000	3,444,550,000
GERMANY/KfW	9,734,502,500	8,412,032,950	6,544,645,000
IRELAND	10,204,444,000	10,880,560,000	11,711,470,000
USAID	64,258,686,105	65,074,360,880	
JAPAN	4,252,064,800	3,702,630,000	201,800,000
FINLAND			
CANADA	9,490,012,736	8,706,922,611	6,496,708,717
ITALY	1,741,042,720		
NETHERLANDS	18,085,659,689	14,759,388,515	909,361,200
FRANCE			
BELGIUM	1,140,252,629	1,155,012,246	623,199,009
BADEA	2,799,750,000	567,200,000	
WFP	2,167,342,470	2,942,184,378	2,980,569,659
Grand Total	214,116,162,340	187,513,500,985	58,181,067,152

Source: Ministry of Finance

1. The above data is based on Donor Commitments/projections submitted in October 05 – March 06

2. The data includes partners support under sector basket and project to health and HIV/AIDS sectors to the Government, NGOs and private sector.

2.7.2 Available data from donors in Zanzibar indicate that external development assistance for health-related activities has been decreasing over the last 12 years and is very small at present. The estimated flow of funds in 2003/2004 was at a level of USD 36 million (excluding the 4.5% share of the Union's program support estimated at TZS 14.5 billion). This equals over USD 50 per capita, all sectors included, of which 30% was allocated to education, health, HIV and water, with HIV/health receiving 17%. It should be noted that part of the HIV/health support is channeled through non-governmental agencies and part through other government departments, such as Ministry of Education, Ministry of Youth, and Ministry of Finance and Economic Affairs.

3. THE SUB SECTOR

3.1 Project Context

3.1.1 Although effective measures to prevent high maternal mortality and morbidity are known, they remain unavailable to poorer segments of the population. A large proportion of these deaths are avoidable. Social determinants such as poverty, social exclusion and low levels of education all contribute to maternal mortality. On the Mainland, 47% of births are facility based. The caesarean rate is about 3%. The poor utilization of services reflects the existing poor quality of health services. Similarly, the low caesarian rate confirms the fact that most obstetric emergencies do not reach health facilities providing Emergency Obstetric Care. The reasons behind the low percentage of birth attended by skilled health personnel and the low rate of facility based births are related to problems both at facility and community levels. Choice of place of birth is determined by where women or their families feel they get the best help. Not receiving appropriate care at facility level, being made to wait, or being turned away for lack of personnel are important factors affecting health seeking behaviors as are, lack of equipment, lack of privacy during labour, and being treated discourteously by staff. At the community level a number of socio-cultural factors including

women's lack of empowerment and inadequate involvement of men in reproductive choices also affect the health seeking behavior of pregnant women

3.1.2 Table 3.1 below shows large disparities between levels of education and the use of maternal health services. The Table suggests that the provision of quality maternal health services and sensitizing communities, go a long way in increasing facility based deliveries and thus reducing maternal mortality. The 2004 data from the ADB supported project in the Dar-es-Salaam Urban Health Facilities indicates that deliveries at Amana Hospital increased by 48 % after improvements were made to the maternity ward and deliveries doubled in some of the 6 dispensaries after MCH Units with labour wards were constructed.

Table 3.1
Disparities by Level of Education in the Use of Maternal Health Services

<u>Antenatal/Delivery</u>	<u>Little or no Education</u>	<u>Secondary and Higher Education</u>
Told of Complications	36.4%	65.7%
Blood Pressure Taken	53.1%	92.9%
Urine Taken	26.0%	84.1%
Given Anti-malarial Tablets	39.7%	58.2%
Cesarean Section	1.1%	12.6%
Home Births	67.5%	14.9%

Source: Health Research for Action (HERA) 2005

3.1.3 In Zanzibar substantial gains were made with regard to births attended by skilled health staff, up from 35.2% in 1992 to 50.8 % in 2004/5. This has been largely due to community based information campaigns and an improvement of facilities. The major direct causes of maternal mortality in Tanzania are antepartum and postpartum haemorrhage (28%), complications of illegal abortion (19%), eclampsia (17%), obstructed prolonged labour (11%), and infections (11%). Indirect causes of maternal mortality include malaria, anaemia, HIV/AIDS, and other related conditions. Given the fact that the majority of maternal deaths occur during labour, delivery and the immediate postpartum period the key to addressing this problem is to ensure availability of emergency obstetric care services.

3.2 Government Strategy

3.2.1 In Mainland, reproductive health care services are available at community level and the various levels of the health system i.e. dispensaries, health centers and hospitals and through outreach services. These services include family planning, counseling, post abortion care, prevention and treatment of obstetric fistula, prevention of mother to child transmission of HIV, and screening of sexually transmitted infections. The Ministry of Health and Social Welfare was until 1999 placing emphasis on training traditional birth attendants (TBAs) in prenatal screening to identify women at "high risk" of developing obstetric complications and supplying them with kits to avoid infections. In spite of the many activities that have been put in place to improve reproductive health care, MMR has remained high, leading to the conclusion that TBAs are not effective in reducing maternal mortality. Furthermore, given the fact that 15% of all pregnant women are at risk of developing some life threatening obstetric complications for which TBAs are not in a position to assist, training of the latter has been abandoned in favor of promoting deliveries by skilled health attendants.

3.2.2 In an effort to address the issue of high maternal mortality ratio and related disparities, the MOHSW (Mainland) has prepared a draft National Road Map Strategic Plan to Accelerate the Reduction of Maternal and Newborn Deaths (2006/10). The Road Map covers the following key strategies:

- Equitable Access to Quality Health Services - identify the underserved areas and provide basic and comprehensive Emergency Obstetric Care.
- Promotion of Reproductive Health Behaviour - promote change of behaviour in order to accelerate the reduction of maternal and newborn deaths.
- Advocacy - to change laws/policies etc. affecting effective implementation of maternal and newborn care.
- Referral System - provide communication equipment in hospitals, health centres and selected dispensaries.
- Capacity Building - increase the knowledge and skills of service providers so that they can provide quality of care. Skills for Planning and Management of maternal newborn care including FP and Nutrition will be imparted to the CHMTs.
- Research, Monitoring and Evaluation - Operational research is essential while implementing interventions. Quality monitoring tools and indicators will be developed, utilized consistently with national Health Management Information System (HMIS).
- Collaboration and Partnership - The MoH in collaboration with PMORALG (The regional secretariat: RAS), Council Management Teams (CMTs) and CHMTs will facilitate the process for strengthening partnerships at region and district level.
- Financial Resources - Among other things the community will be educated and sensitized to mobilize funds at the village level in order to be prepared when obstetric emergencies occur at the community level.

3.2.3 In Zanzibar the Draft Reproductive and Child Health Strategy (2006-2010) prioritises Maternal and Child health, as well as adolescent sexual reproductive health, the involvement of males in reproductive health, and the reproductive health of the elderly. Strategies include training in lifesaving skills, increasing early bookings for ANC, facilitating birth plans, increasing facilities which offer post-abortion care, and community sensitization.

3.3 Constrains and Challenges

3.3.1 Both Mainland and Zanzibar have enacted policies concerning gender equity and women's development (2000 and 2001). The main objectives of the policies are guidance on gender mainstreaming through all sectors with special attention being given to women's ownership of property, and participation in decision making. Constitutionally, women should make up no less than 30 percent of members of the Tanzanian Parliament and the Zanzibar House of Representatives. There have been successes in this regard, in Local Government 33.3 percent of seats are reserved for women. In the education sector gender parity has almost been achieved with regard to net enrolment in primary school where in 2006 the gender parity index was 0.99. In secondary school NER is higher for girls in Form 1 to 4 and close to parity in the higher grades (1.1 to 0.9 %).

3.3.2 In spite of these successes many challenges remain. Tradition and customary law, which largely favor men both in Mainland and Zanzibar still prevent women from making full use of legal and political advances. Violence against women poses another threat, as do female genital mutilation which is still practiced in parts of Mainland Tanzania, including Mara. Poverty levels are generally high in Mainland (39 % rural, 18 % urban) as well as Zanzibar (61% poor, 21% very poor), and are particularly high among women due to their lack of economic empowerment. These factors and the lack of decision-making regarding reproductive health as well as the lack of adequate facilities contribute to high levels of home based deliveries.

3.3.3 The health system in Tanzania remains weak and cannot adequately respond to the health needs of its people in particular that of mothers and newborns. The health system is characterized

by inadequate number of skilled health workers, lack of needed equipment, dilapidated facilities and a poor referral system due to lack of transportation and communication systems. Currently only 64.5% of hospitals are providing comprehensive Emergency Obstetric Care whereas, only 5.5% of health centres are providing Basic EmOC and only 5 % of health facilities provide comprehensive PAC. Dispensaries don't have adequate space for MCH activities, health centres and some hospitals don't have theatres and skilled health personnel to provide Emergency Obstetric Care. In Zanzibar 6 of the 16 second line dispensaries don't have adequate facilities to provide MCH services. It is also estimated that 25 of the 126 posts for clinical officers and 700 of the 1,128 of core medical posts at the primary level in Zanzibar are filled.

3.3.4 The low student output at the CHS (paragraph 2.4.3) is worsened by high shortages of tutors. The College also has inadequate infrastructure for the required numbers of students as well as inadequate teaching resources and equipment. There is therefore, need to target improvements at the CHS on PHC workers who cover maternal health care services.

4. THE PROJECT

4.1 Project Concept and Rationale

4.1.1 Tanzania endorsed the resolution to address effectively the issue of high MMR during the Nairobi International Conference on Safe Motherhood in 1987. Many interventions have since been implemented with the view to reducing MMR. In spite of these efforts, the MMR has remained high for the last 10 years: 529/100,000 live births ((DHS 1996) and 578/100,000 live births ((DHS 2004/05). The quality of available maternal health services in Tanzania is reflected by the low caesarean rate, institutional deliveries and births attended by skilled personnel. As indicated in paragraph 2.6.3 the major problems in reducing MMR are (i) lack of skilled attendance during labour/delivery; (ii) accessing Emergency Obstetric Care (EmOC) in the event of obstetric complications and (iii) supportive environment in which skilled attendants can perform effectively. The two studies in Mainland and Zanzibar have provided a substantial amount of information which has identified a number of structural and systemic problems which impact negatively on health service delivery at the district level. These studies have shown that the health system in rural areas is characterized by inadequate number of skilled health workers, lack of equipment, dilapidated facilities and a poor referral system.

4.1.2 Government decided to start taking corrective measures in the three regions and Zanzibar since the two ADF financed studies provide drawings, bills of quantities and tender documents ready for implementation. In consultation with the beneficiaries and Local Government Authorities, the project has been designed to support three of the priority sectoral activities in the HSSP namely, (i) rehabilitation of health facilities, (ii) reproductive and child health and (iii) human resources development. As shown in paragraph 3.1.2, provision of MCH Units and labour wards in dispensaries has increased their utilization significantly. In addition to improving the quality of EmOC, the project will address socio-cultural factors that lower facility based deliveries, namely by increasing male involvement in planning facility based births which will benefit maternal health and complement various activities by other donors supporting interventions in reproductive health (Annex IV for Mainland). The project will be implemented within the SWAp arrangement using Bank Group procurement and disbursement procedures in line with the HSSP, and the Tanzania Joint Assistance Strategy which is open to other funding modalities during the transition period

4.1.3 The project is in line with the Bank Group's Updated CSP which places emphasis on human capital and the Health Policy which seeks to assist member countries attain higher and sustainable pro-poor economic growth and address challenges posed by the increasing burden of disease. As indicated above, the project supports priority sector activities in the HSSP (2003-08) and conforms

to the Tanzania Joint Assistance Strategy. It is also inline with the 2005 National Strategy for Growth and Reduction of Poverty (NSGRP) which seeks to improve survival, health and well-being of all children, women and vulnerable groups. The project will empower the community to create a demand for access to a continuum of care between the household and the health care facility. The project will therefore, address the three delays that cause most of pregnancy-related mortality, namely, delays in: (1) deciding to seek appropriate medical help for an obstetric emergency; (2) reaching an appropriate obstetric facility; and (3) receiving adequate care when a facility is reached.

4.1.4 The project will be the 5th Bank Group operation in the health sector. The total amount committed to date in the sector is UA 16.46 million. The previous four interventions comprised three studies and the ongoing First Health Rehabilitation Project (ADF UA 15 million). The design of the project has taken into account the following lessons learned and recommendations from previous interventions as highlighted in the Tanzania, Evaluation of Bank Assistance to the Health Sector (OPEV, 2005): (i) investments in health care in rural areas as evidenced by the regions selected; (ii) a participatory approach during project appraisal where workshops were organised in the three regions and Zanzibar involving stakeholders; (iii) provision of accommodation to enhance staff retention. It has also taken into account recommendations from the recently completed Country Portfolio Review for Tanzania (2006) in order to reduce delays in fulfilment of conditions and project implementation: (i) reduce number of components, (ii) rationalise conditions for entry into force in order to minimize delays in project start up, (iii) include post review in procurement of goods, works and services, (iv) the role of the Country Office, and (v) the unique relationship that exists between the Mainland and Zanzibar.

4.2 Project Area and Beneficiaries

4.2.1 The project area consists of Mara, Tabora and Mtwara Region on the Mainland and the Islands of Zanzibar (Annex I). The three regions consist of 17 districts with a total population of approximately 3.1 million or 12% of the total population of the country. A profile of the project area is presented in Table 3.1. below.

Table 4.1
Demographic and Health Profile of the Project Area

Indicator	Mainland	Mara	Mtwara	Tabora	Zanzibar
2002 Population Estimate (millions)	33.58	1.37	1.13	1.71	.98
Percent Rural	80	87	74	80	60
% of deliveries attended by trained health worker	47	<35	35 - 41	>55	50.8
% of births at home	52.8	68.5	62.8	46..3	
% of unmet need for family planning	21.6	28.2	23.6	23.4	31.3

Sources: *Demographic Health Survey 2004 - 05; Poverty and Human Development Report 2005*

4.2.2 Although Tanzania has achieved relative success in providing basic health services to its population, the level of achievements in the proposed project area is much lower than the average for the rest of the country. The health system remains weak and cannot adequately respond to the health needs of its people in particular that of mothers and newborns. Percentages of births delivered at home are well above the national average. On the average, only about one-third of births are attended by trained health personnel while contraceptive use by females of childbearing age in Mara and Mtwara are among the lowest in the country.

4.2.3 Each of the 17 districts serves an average population of about 300,000. District health services are provided through a network of at least a district hospital (either governmental or a voluntary agency), health centers (serving a population of 50,000 -70,000), dispensaries (serving a population of 6,000 -12,000) and village health workers (one per village). Findings from the recent studies showed that poorly trained staff at all levels of care at the regional level, serious

deterioration of physical infrastructure and equipment, limited budgetary allocations for maintenance and resultant deterioration of staff morale have all compromised the quality in provision of maternal health care in the project area.

4.2.4 The major beneficiaries of the project will be predominantly poor communities utilizing the services at the peripheral level. Training of tutors in Zanzibar will increase intake of students to enable deployment of full-time, qualified staff. The capacities and competencies of staff serving at primary level will also be enhanced through a continuing program of PHC skills upgrading, targeting all health workers. Provision of staff-housing at health centers in the three regions and PHC units in Zanzibar will help ensure that communities have access to a health provider at all times, especially during emergencies. The provision of housing will also contribute to staff retention in remote areas. Participatory approaches to community engagement will improve knowledge of reproductive health risks, facilitate advance planning for birth preparedness and increase acceptability of facility based deliveries.

4.3 Strategic Context

The proposed project intends to develop effective EmOC in Mara, Mtwara, Tabora and Zanzibar. It will address major obstacles to implementing and scaling-up appropriate maternal health care programmes. It will also contribute to Government's efforts to addressing the human health resources crisis. Furthermore, the project will contribute towards Government's efforts to attain MDG number 4 and 5 i.e. reduction of child mortality and improve maternal health, and the 2005 NSGRP targets related to maternal and child health as outlined in Annex V. The project conforms to the goals of Cluster II of NSGRP which seeks to improve survival, health and well-being of all children and women and of especially vulnerable groups. It also conforms to the Zanzibar Strategy for Growth and Reduction of Poverty which is similar to NSGRP as well as those of the Women and Gender Development Policy (2000) on the Mainland and the Policy on the Protection and Development of Women (2001) in Zanzibar, both of which stress the empowerment of women and their access to improved health care services.

4.4 Project Objective

The sector goal is to improve the health and well-being of Tanzanians and the project objective is to accelerate the reduction of maternal and newborn deaths in Mara, Mtwara, Tabora and Zanzibar.

4.5 Project Description

4.5.1 The project will comprise the following components:

- i) Component I – Strengthened Delivery of Maternal Health Services (Mainland)
- ii) Component II – Strengthened Delivery of Health Care Services (Zanzibar)
- iii) Component III – Management and Coordination.

Component I - Strengthened Delivery of Maternal Health Services (Mainland)

4.5.2 The project will provide an enabling working environment and ensure accessibility to quality health care services by providing adequate space including MCH units at dispensary and obstetric theaters at health centers and some selected district hospitals as prioritized under the Three Regions Health Study. All new and existing facilities that do not have appropriate water and sanitation facilities will be provided with boreholes, VIP latrines and placenta pits. All health facilities will be linked to a common call radio network and eight district hospitals will be provided

with an ambulance. Given the current shortages of health workers, the project aims at increasing intake of various health cadres at selected training institutions and at updating skills of health workers through in-service training especially on emerging maternal and child health issues.

4.5.3 The above component will be achieved through a range of activities under the following categories of expenditure:

(A) Civil Works

4.5.4 Civil works will involve full rehabilitation of facilities noted to be in a deplorable state as well as extensions to improve maternal health. The following activities will be undertaken; (i) construction of new MCH Units at 104 dispensaries, in addition 36 of these dispensaries will be fully rehabilitated as they are in a dilapidated state and 22 will be incorporated under construction of new standard dispensaries at existing locations where the present structures will be demolished (ii) construction of new obstetric theaters at 36 health centers including full rehabilitation of 8 of these health centers, and (iii) construction of 10 new obstetric theaters at district hospitals including full rehabilitation of 2 of these district hospitals in Mara and Tabora. Mtwara will not be included since its district hospitals will be rehabilitated using Kfw funds. Construction works will also include provision of appropriate water and sanitation facilities as well as solar energy at selected facilities. Furthermore, a staff house will be provided at each of the 36 health centers to accommodate Assistant Medical Officers who are critical for running the obstetric theaters.

4.5.5 Two training institutions in Tabora and Mtwara regions have been identified and these institutions will be rehabilitated and upgraded to include additional classrooms and dormitories to meet increased output requirements. These institutions are used for training various health cadres including assistant medical officers who are critical for operating obstetric theaters at health centers in order to provide EmOC.

(B) Goods

4.5.6 All the rehabilitated and upgraded facilities (104 dispensaries, 36 Health centers and 10 district hospitals) will be provided with furniture and biomedical equipment in line with the recommended standards.

4.5.7 In order to improve the referral system, all government facilities and private not for profit designated district hospitals in each of the three regions will be supplied and connected to a network of radio call system. The project will also provide an ambulance to 8 district hospitals with no ambulances. These ambulances will be fully equipped with radio system.

4.5.8 About 1200 job aids on clinical management in obstetric care will be updated and distributed to all health facilities for use in community education in the three regions.

4.5.9 The two rehabilitated and upgraded training institutions will be provided with furniture, equipment and learning materials. The training institutions will prepare the details of the requirements.

(C) Services

4.5.10 The designs and tender documents for the rehabilitation and upgrading requirements have been done under the Three Regions Health Study. However, the project will fund consultants to provide post-contract services and capacity building activities. The consultant will supervise the works during construction phase up to the end of maintenance period; and provide on the job training to district engineers and technical staff at Regional Administrative Secretariat.

4.5.11 PMORALG has developed a procedures manual for project management and maintenance of health facilities. In order to re-orient CHMTs and RHMTs, the project will provide resources to undertake workshops on project management and maintenance. This will cover all districts in the country. However, this will be done through 3 workshops organized in the three regions but to include participants from other districts and regions in the North, Central and South to be undertaken in Mara, Tabora and Mtwara regions respectively.

4.5.12 The project will provide resources for in-service training of various health workers (clinical officers, midwives, nurses etc.) through workshops in order to update their knowledge and skills in provision of services pertaining to maternal and newborn health care as follows:

- 300 health workers will be trained in life saving skills through two week duration workshops. This training will be targeting assistant medical officers, clinical officers and nurses from district hospitals, health centers and dispensaries.
- 600 health workers will be trained in focused antenatal care through two week duration workshops. The workshop will also address the need for client friendly service delivery. The target will be nurses and midwives who manage and operate facility based and antenatal clinics.
- 120 health workers will be trained in post abortion care through one week duration workshops. This training will target assistant medical officers, clinical officers and nurse/midwives and will focus on post abortion clinical and psychosocial care with the purpose of identifying risk factors which might be addressed during subsequent pregnancies.
- 450 health workers will be trained in family planning through one week duration workshop. This training will target staff manning facility and outreach based MCH clinics.
- The 3 RHMTs and 17 CHMTs will be trained on evidence based planning of MCH interventions.

4.5.13 The project will provide resources to mobilize and train communities in MCH interventions in order to strengthen the interface between the households and the health facilities. This will involve training 34 trainers of trainers i.e. 2 per district, MCH Coordinator and Community Development Officer. These will act as facilitators and they will be responsible for training 352 health workers (1 per facility) at facility level. The health worker at facility level in liaison with the villages will be responsible for identifying and training 800 community resource persons or village health workers in the project area. Special emphasis should be placed on training both men and women as resource persons at facility and community level in order to ensure male involvement in reproductive health matters. IEC/BCC materials will be printed and distributed to the facilities and the community resource persons will use these materials during their training campaigns.

4.5.14 Thirty tutors will be provided with scholarships in order to upgrade their qualifications locally. Equal number of men and women should be targeted for training.

Component II: Strengthened Delivery of Health Care Services (Zanzibar)

4.5.15 The project aims at strengthening delivery of health care services in Zanzibar. A two-pronged approach to strengthen human resources will be adopted. In the long-term, trainee tutors will be recruited and trained in various specialties to fill the vacant posts at the College of Health Sciences (CHS), whilst with the assistance of WHO and the Commonwealth Health Secretariat TA tutors will be recruited in the short term. Scholarships will be provided to enable students from Zanzibar, in particular those from Pemba, to undergo health training programs on the Mainland. Post-training

bonding measures will be applied to mitigate the risk of losing trained workers. In order to increase the intake of students within Zanzibar, and to guarantee placement and accommodation for qualifying students from Pemba, the CHS will be upgraded with additional dormitories, classrooms, staff quarters and ancillary facilities and services. All female students will be guaranteed accommodation if it is required. Six second-line dispensaries will be upgraded to assist in meeting PHC demands and maternal health services. The project will further complement rehabilitation of 1st line dispensaries undertaken by DANIDA through construction of junior level housing units for officers in charge of some of these facilities. DANIDA is currently supporting strengthening of facilities and equipment maintenance and has a functioning maintenance unit at Mnazi Moja Hospital in Unguja. Maintenance of new and rehabilitated facilities and equipment will benefit from the DANIDA intervention.

4.5.16 The details of the categories of expenditure under the above component are as follows:

(A) *Civil Works*

4.5.17 The College of Health Sciences will be provided with: a 2x1,000m² academic block with each block having ten new furnished classrooms with a capacity of 35 students each; a new laboratory; a new practical room; two new 800m² 100-bed dormitories (female and male); two 300m² staff quarters for eight tutors; and minor associated works to enable increased intake to the recommended level.

4.5.18 Three incinerators at 3 health facilities in Pemba will be erected to improve medical waste management and disease prevention, in support of other PHC medical waste management activities.

4.5.19 Upgrading of the 6 second-line dispensaries involves extension of the existing PHC unit, construction of an MCH unit waiting shed, an ablution block, a laboratory, and minor external works. In addition a total of no more than 40 junior-level staff housing units will be provided at PHC facilities (1st and 2nd line dispensaries) towards providing concrete incentives for staff to remain on the islands within the PHC delivery system and also to ensure that officers-in-charge are always available at PHC facilities, especially during emergencies. Rural health facilities shall be provided with double housing units to accommodate two staff members.

(B) *Goods*

4.5.20 The newly built classrooms and dormitories at the College will be provided with furniture. Equipment, including computers and teaching aids, shall be provided for the classrooms. The College of Health Sciences and the project Management Unit shall provide the Bank with standard specifications for all furniture and equipment before tendering.

4.5.21 The second-line dispensaries, housing units and Mental Health Unit will be provided with some furniture and equipment.

4.5.22 The maintenance team is currently assisted by the DANIDA project and their major constraint is supplies for preventive maintenance. In this regard, the project will provide supplies estimated at USD 50,000 per year. The team will draw up the supplies and list of consumables on an annual basis.

(C) *Services*

4.5.23 The project will provide training for 100 senior PHC staff on emerging public health problems and medical procedures, 450 PHC staff on community participation in health, and 50 clinical officers to head PHC units. Ten clinical officers will be upgraded to Assistant Medical Officers to serve in PHC Centers, 10 dental therapists will be upgraded to Assistant Dental Officers to staff 2nd line dispensaries. Fifteen tutors will be trained at diploma and degree level in various

specialties to allow them to teach at the College of Health Sciences and 3 non-academic College Health of Science staff will be trained at diploma and degree level. All training activities will target both men and women and as far as possible strive towards gender balance.

4.5.24 The project will provide 30 scholarships (3 for each of the 10 districts) for serving members of the DHMTs to undertake diploma and degree level courses on the Mainland. Ten of these scholarships (1 for each of the ten districts) will be for the training of District Environmental Health Officers who will oversee the supervision and monitoring of medical and other waste disposal at health facilities.

4.5.25 The project will provide 25 scholarships each year in the first two years for students from Zanzibar to undertake basic training on the Mainland to supplement the training available at the CHS. A total of 50 students will receive scholarships over the life of the project. The project will provide funds to train 5 professional staff and 5 technicians in operational and maintenance procedures. Women will be considered preferentially in order to redress existing gender imbalance.

4.5.26 A consultant for 6 person months will be recruited to conduct a training needs assessment and skills audit of all PHC level health workers. This will be followed by the development of a training plan. Provision will be made for mentorship of the training unit staff to enable them to manage the process at the end of the term of the consultant. Provision has also been made for the implementation of the plan that will allow all PHC workers to benefit from a range of short to long term courses and in-service training in a manner which will be least disruptive to patient care.

4.5.27 A consultant for 4 person months will be recruited to review the College of Health Sciences curriculum, hold a workshop to review the revised curriculum with all stakeholders, and orient users in the revised curriculum. Another consultant for 4 person months will be recruited to develop a business plan and marketing tools for sustainability of the College.

Component III: Management and Coordination

Mainland

4.5.28 The project will be implemented in the three regions through the various existing Local Government structures i.e. Facility Health Committee (FHC), CHMT, RHMT and RAS. Considering that technical capacity is limited, the project will provide resources for recruitment of a consulting firm which will provide as a minimum a Resident Engineer and Public Health Specialist at regional level who will coordinate and supervise the activities on a day to day basis and provide capacity building related activities by training regional and district officers. The consulting firm will liaise closely with all local government management teams at various levels.

4.5.29 However, there is need for coordination of activities at National level. The MOHSW will be the executing agency and the Policy Planning Division will nominate suitable staff from within the existing structure for the positions of Project Manager, Quantity Surveyor, Architect, Procurement Specialist, Services Engineer and an Accountant and where possible reinforced accordingly. The Reproductive and Child Health Section will nominate to the project a suitable Public Health Specialist to be responsible for coordinating MCH training activities. The team at National Level will be responsible for preparing quarterly progress reports consolidated from regional submissions, all procurement matters in accordance with ADF procedures and processing all disbursements including financial reporting.

Zanzibar

4.5.30 Due to the weak capacity of the MOHSW and in order to effectively manage project resources on the two islands, a project Management Unit (PMU) comprising six professional and five support staff is proposed. The PMU will be provided with moderate office accommodation and some equipment and furniture.

4.5.31 The details of the categories of expenditure under the above component are as follows:

(A) Works

4.5.32 The project will refurbish offices at the MOHSW in Zanzibar to accommodate the Project Management Unit.

(B) Goods

4.5.33 On the Mainland the project will provide general office equipment and furniture including a motor vehicle for use by the Coordination Team within the Planning Department. In addition, all District Engineers will be provided with a motor cycle for supervising the works.

4.5.34 In Zanzibar the PMU will be provided with office equipment including a photocopier, 10 computer workstations and accessories. Two vehicles will be provided, one each in Pemba and Unguja to facilitate supervision of civil works.

(C) Services

4.5.35 The project will support recruitment of the following 6 technical assistants: 1 Project Manager, 1 Engineer, 1 Architect, 1 Health Planner/M&E Specialist, 1 Procurement Specialist, and 1 Accountant, for the PMU. The professional composition of the PMU will ensure that construction works can be supervised adequately on both islands.

4.5.36 The project will support procurement of the services of external auditors to carry out annual project audits.

(D) Operating Costs

4.5.37 This will consist of top up allowances and operating costs relating to the implementation, monitoring and management of the project by the nominated staff from the existing structure of the Planning Department on the Mainland and PMU operating costs for the duration of the project in Zanzibar.

4.6 Environmental Impact

4.6.1 The project has been classified as category II in view of the civil works comprising rehabilitation and new construction mainly extension of single storey small-scale buildings at dispensaries, health centres, district hospitals and training institutions. By providing functional health facilities, the project will contribute positively to the social and human environment through improved provision of PHC services. The negative aspects of de-vegetation, soil erosion and formation of gullies, dust and noise will be mitigated by re-vegetation after completion of the works and construction of appropriate drainage systems. During construction, contractors will observe mitigating measures to preserve natural elements on the site and minimize dust and noise disturbances by fencing off work areas.

4.6.2 A borehole will be drilled where not available at each new and extended health facility, providing a safe source of drinking water for the facility and the surrounding community. Where no connection can be made to mains electricity, the project provides for installation of solar units to provide lighting. Solar energy is a clean source of energy and therefore is not expected to have

negative environmental impact. The only potential negative environmental impact may arise from the acids and heavy metals in old batteries when batteries are to be replaced. By ensuring that the old batteries are taken to recycling facilities, any potentially negative environmental impact can be pre-empted.

4.7 Project Cost

4.7.1 The total cost of the project, net of taxes and customs duties, is estimated at UA 44.44 million (USD 65.75 million), of which UA 25.71 million is in foreign exchange and the equivalent of UA 18.73 million is in local currency. For the purpose of costing, all items have been priced in United States Dollars and converted into Units of Account at the exchange rate applicable at the Bank for the month of July 2006. A summary of project cost estimates is given below in *Table 4.2* by component and in *Table 4.3* by category of expenditure.

4.7.2 Cost estimates for civil works are based on unit costs developed by staff from the MOHSW and from the Three Regions Health Study. A physical contingency of 5% is included in the project costs for all categories of expenditure, other than the civil works which has a contingency of 10%. Price contingencies are estimated at an annual 3.5% inflation rate per year on an overall basis for both local costs and foreign exchange costs. The detailed cost estimates are included in the PID and the provisional list of goods and services is shown in Annex VII.

Table 4.2
Summary of Project Costs by Component

COMPONENTS	USD million			UA million			% F.E.
	F.E.	L.C.	Total	F.E.	L.C.	Total	
Component I	24.05	19.61	43.66	16.26	13.26	29.51	55%
Component II	6.66	2.65	9.31	4.50	1.79	6.29	72%
Component III	1.75	1.39	3.14	1.18	0.94	2.12	56%
Base Costs	32.46	23.65	56.11	21.94	15.99	37.93	58%
Physical Contingencies	2.83	1.95	4.78	1.91	1.32	3.23	59%
Price Contingencies	2.75	2.11	4.85	1.86	1.42	3.28	57%
TOTAL COSTS	38.04	27.71	65.75	25.71	18.73	44.44	58%
	58%	42%	100%	58%	42%	100%	

Table 4.3
Summary of Project Costs by Category of Expenditure

CATEGORY	USD million			UA million			% F.E.
	F.E.	L.C.	Total	F.E.	L.C.	Total	
Goods	6.21	2.70	8.91	4.20	1.82	6.02	70%
Works	22.81	14.62	37.43	15.42	9.88	25.30	61%
Services	2.99	5.31	8.30	2.02	3.59	5.61	36%
Operating Costs	0.44	1.03	1.47	0.30	0.70	1.00	30%
Base Costs	32.46	23.65	56.11	21.94	15.99	37.93	58%
Physical Contingencies	2.83	1.95	4.78	1.91	1.32	3.23	59%
Price Contingencies	2.75	2.11	4.85	1.86	1.42	3.28	57%
TOTAL COSTS	38.04	27.71	65.75	25.71	18.73	44.44	58%
	58%	42%	100%	58%	42%	100%	

4.8 Sources of Financing and Expenditure Schedule

4.8.1 The project will be financed jointly by the ADF Loan (UA 40.00 million) and United Republic of Tanzania (UA 4.44 million) as indicated in Table 4.3 below. The ADF Loan will finance 90.0% of the total project cost, and will comprise UA 25.71 million in foreign exchange, representing 58% of total project costs, and UA 14.29 million in local costs, 32% of total project costs. All foreign exchange costs of the project will be borne by the ADF funds. The ADF will wholly fund the costs of goods, services and 85% of the costs for works.

4.8.2 The Government's contribution of UA 4.44 million in local costs, representing 10.0% of the total project cost will partially finance the category of expenditure for works (15%). Tables 4.4(a) and 4.4 (b) shows project costs by source of finance and sources of finance and category of expenditure respectively.

*Table 4.4 (a)
Sources of Finance (UA million)*

SOURCE	F.E.	%	L.C.	%	TOTAL	% of Tot.
ADF LOAN	25.71	100%	14.29	76%	40.00	90%
GOVERNMENT	0.00	0%	4.44	24%	4.44	10%
TOTAL	25.71		18.73		44.44	100%
	58%		42%		100%	

*Table 4.4 (b)
Sources of Finance and Categories of Expenditure (UA million)*

CATEGORY	TOTAL		ADF LOAN		GOVERNMENT	
	Amount	% of Tot	Amount	% of Cat.	Amount	% of Cat.
Goods	6.80	15.3%	6.80	100.0%	0.00	0.0%
Works	29.94	67.4%	25.49	85.0%	4.44	15.0%
Services	6.55	14.7%	6.55	100.0%	0.00	0.0%
Operating Costs	1.16	2.6%	1.16	100.0%	0.00	0.0%
TOTAL	44.44		40.00		4.44	
	100%		100%		100%	

4.8.3 Tables 4.5 and 4.6 below show expenditure schedule by component and by category of expenditure and source of financing respectively.

*Table 4.5
Expenditure Schedule by Component (UA million)*

	2007	2008	2009	2010	2011	TOTAL
1. Strengthened Delivery of Maternal Health Services (Mainland)						
Goods	0.00	0.54	0.71	2.34	2.34	5.93
Works	4.46	6.90	7.53	4.40	1.12	24.41
Services	0.57	1.27	1.27	1.02	0.08	4.22
TOTAL COMPONENT 1	5.03	8.72	9.52	7.76	3.54	34.56
Percentage	15%	25%	28%	22%	10%	100%
2. Strengthened Delivery of Health Care Services (Zanzibar)						
Goods	0.36	0.06	0.06	0.02	0.00	0.49
Works	2.22	3.05	0.06	0.00	0.00	5.33
Services	0.87	0.21	0.19	0.19	0.14	1.60
TOTAL COMPONENT 2	3.45	3.32	0.30	0.21	0.14	7.42
Percentage	47%	45%	4%	3%	2%	100%
3. Management and Coordination						
Goods	0.22	0.04	0.04	0.04	0.04	0.38
Works	0.10	0.10	0.00	0.00	0.00	0.20
Services	0.15	0.15	0.15	0.15	0.15	0.73
Operating Costs	0.23	0.23	0.23	0.23	0.23	1.16
TOTAL COMPONENT 3	0.70	0.52	0.42	0.42	0.42	2.46
Percentage	28%	21%	17%	17%	17%	100%
TOTAL PROJECT	9.18	12.55	10.24	8.38	4.09	44.44
	21%	28%	23%	19%	9%	100%

*Table 4.6
Expenditure Schedule by Category and Source of Finance (UA million)*

ADF LOAN	2007	2008	2009	2010	2011	TOTAL
Goods	0.58	0.64	0.81	2.39	2.38	6.80
Works	5.77	8.56	6.47	3.74	0.95	25.49
Services	1.59	1.63	1.61	1.36	0.37	6.55
Operating Costs	0.23	0.23	0.23	0.23	0.23	1.16
Total	8.18	11.06	9.11	7.73	3.93	40.00
Percentage of Total	20%	28%	23%	19%	10%	100%
G O V E R N M E N T	2007	2008	2009	2010	2011	TOTAL
Goods	0.00	0.00	0.00	0.00	0.00	0.00
Works	1.01	1.49	1.13	0.65	0.17	4.44
Operating Costs	0.00	0.00	0.00	0.00	0.00	0.00
Total	1.01	1.49	1.13	0.65	0.17	4.44
Percentage of Total	23%	34%	25%	15%	4%	100%
T O T A L	2007	2008	2009	2010	2011	TOTAL
Goods	0.58	0.64	0.81	2.39	2.38	6.80
Works	6.78	10.05	7.59	4.40	1.12	29.94
Services	1.59	1.63	1.61	1.36	0.37	6.55
Operating Costs	0.23	0.23	0.23	0.23	0.23	1.16
Total	9.18	12.55	10.24	8.38	4.09	44.44
Percentage of Total	21%	28%	23%	19%	9%	100%

5. PROJECT IMPLEMENTATION

5.1 Executing Agencies

5.1.1 The individual Ministries of Health and Social Welfare will be the executing agencies. On the Mainland, the project will be implemented in the three regions through the various existing Local Government structures. At facility level, the Facility Health Committee will be closely involved in monitoring implementation of the rehabilitation and upgrading of the facilities and training of the communities. At District level, the CHMT will oversee the implementation of the activities in the District and the DMO and the District Engineer will work closely with the

consultants in reviewing progress and certificates for payment. At regional level, the RHMT will oversee the implementation of the project in each region. The RMO in liaison with the RAS will review progress and consolidate the progress reports from the districts.

5.1.2 However, the overall coordination of the three regions at National level will be through the Policy and Planning Division of the MOHSW. The MOHSW through the Policy and Planning Division will nominate from the Building Section suitable candidates for positions of Project Manager, Quantity Surveyor, Architect, Procurement Specialist, Services Engineer and Accountant from within the present set up and where possible reinforced accordingly. The Public Health Specialist will be seconded to the project from the Reproductive and Child Health Section. The Project Manager with his team will be responsible for the overall coordination of the project including reporting to ADF.

5.1.3 In Zanzibar, the Planning Department does not have the staff and capacity to manage the project. For this reason, a Project Management Unit (PMU) comprising eight professional staff and five support staff will be established to supervise the project. This team will consist of a Project Manager, an Assistant Project Manager (based in Pemba), an architect, an engineer, a health planner, a procurement specialist, an accountant, and a monitoring and evaluation specialist. As shown in Annex III, the PMU will report to the Principal Secretary and will liaise closely with the departments at the MOHSW to ensure that project activities are in line with departmental strategies. The Project Manager will act as Secretary to the Steering Committee. The PMU will be responsible for the overall technical, administrative and financial control of the project, including reporting to ADF. Specifically, the PMU will be responsible for the coordination of all work programs and annual budgets. It will also oversee all aspects of construction management from tendering to final completion and release of retention funds.

5.2 Institutional Arrangements

5.2.1 On the Mainland, overall oversight for the project management will rest in an inter-ministerial Steering Committee, which is headed by the Permanent Secretary, Ministry of Health and Social Welfare, comprising Director General – Health Services; Directors for Policy Planning Division; Preventive Services; Hospital Services; and Human Resources Development; Head, Health Sector Reform; Regional Administrative Secretaries for Mtwara, Mara and Tabora; and a representative from the District Health Infrastructure Rehabilitation Component, PMORALG. The Steering Committee will meet quarterly to coordinate inter-ministerial activities of the project with those of the regions, districts and monitor progress. Similarly at district level a committee chaired by the District Executive Director will monitor project implementation. The PMORALG will play a major role through CHMTs by involving the community during the whole process of planning, monitoring and evaluation of rehabilitation and provision of MCH activities.

5.2.2 The Directorate of Policy and Planning Division of the MOHSW through the nominated Project Manager will liaise closely with each of the technical departments at the MOHSW to ensure that project activities are in line with the departmental strategies. The Project Manager will be responsible for the overall technical, administrative and financial control of the project, including reporting to ADB. In addition, responsibilities will include coordination of the work programmes and annual budgets for all the components. The nominated technical team members will oversee tendering, and selection of contractors for construction.

5.2.3 Within the framework of SWAs, the Reproductive Health Technical Working Group chaired by the Director, Preventive Services will have technical oversight over the project and provide technical advice to the Steering Committee. The Working Group will also advise the project on best practices in the area of community participation and quality improvement of reproductive health care

and recommend necessary changes to project activities. To ensure effective policy consultations, the Steering Committee will report to the SWAps Committee which meets twice a year (paragraph 5.8.1). The SWAps Committee will in turn report to the Joint Annual Review Meeting. TZFO will be actively involved in all the technical working groups and review meetings.

5.2.4 In Zanzibar, an inter-ministerial Steering Committee, which will have overall oversight of the project will be formed and chaired by the Principal Secretary, MOHSW. Other members will comprise all the major project stakeholders and beneficiaries, including MOHSW heads of departments, the Pemba Health Co-ordinator, the Principal of the CHS, the Project Manager (Secretary to the Steering Committee), and a representative from the Ministry of Finance and Economic Affairs. The Steering Committee will meet quarterly and the PMU shall ensure that minutes of Steering Committee meetings are summarized in the QPPR for the respective reporting period.

5.3 Supervision and Implementation Schedules

The project will be implemented over a period of 5 years (60 months) starting from the date of Loan Effectiveness. The implementation schedule in Annex VI gives the tentative timing for project activities. Administration activities are summarized as follows:

<u>ACTIVITY</u>	<u>RESPONSIBLE AGENCY</u>	<u>TARGET DATE</u>
<u>Administration:</u>		
Appraisal Mission	ADF/GOT	June/July 2006
Loan Negotiations	ADF/GOT	August 2006
Loan Approval	ADF Board	September 2006
General Procurement Notice	ADF/GOT	September 2006
Loan Signature	GOT/ADF	October 2006
Entry into Force	GOT/ADF	December 2006
Project Launching	ADB/GOT	January 2007
Quarterly Progress Reports	GOT	2007-2011
Borrower's Project Completion Report	GOT	2011
ADB Project Completion Report	ADF	2011

5.4 Procurement Arrangements

5.4.1 Procurement arrangements are summarized in Table 5.1 below. All procurement of goods, works and acquisition of consulting services financed by the Bank will be in accordance with the Bank's *Rules of Procedure for Procurement of Goods and Works* or, as appropriate, *Rules of Procedure for the Use of Consultants*, using the relevant Bank Standard Bidding Documents.

Table 5.1
Summary of Procurement Arrangements
(UA million)

CATEGORIES	ICB	NCB	SHORTLIST	OTHER	TOTAL
1. WORKS					
1.1 Rehabilitation and Extension Health Facilities (M)		22.31[18.75]			22.31[18.75]
1.2 Rehabilitation of three Training Institutions (M)		2.10[1.72]			2.10[1.72]
1.3 Extension of CHS and Incinerators (Z)		1.63[1.63]			1.63[1.63]
1.4 Upgrading 2nd line Dispensaries, Housing		3.70[3.70]			3.70[3.70]
1.5 Refurbishment of PMU Offices (Z)		0.20[0.20]			0.20[0.20]
2. GOODS:					
2.1 Furniture for rehabilitated facilities (Mainland)		1.51[1.51]			1.51[1.51]
2.2 Biomedical Equipment for Facilities (Mainland)	3.16[3.16]				3.16[3.16]
2.3 Radio Communication Equipment	0.61[0.61]				0.61[0.61]
2.4 Ambulances				0.24[0.24]	0.24[0.24]
2.5 Printing Job Aids				0.05[0.05]	0.05[0.05]
2.6 Furniture and Equipment Training Institutions (M)		0.28[0.28]			0.28[0.28]
2.7 Teaching and Learning Materials (Mainland)		0.08[0.08]			0.08[0.08]
2.8 Furniture and Equipment for CHS		0.17[0.17]			0.17[0.17]
2.9 Furniture for 2nd Line Dispensaries (Zanzibar)		0.13[0.13]			0.13[0.13]
2.10 Equipment for 2nd line Dispensaries (Zanzibar)		0.20[0.20]			0.20[0.20]
2.11 Office Equipment (Zanzibar)		0.28[0.28]			0.28[0.28]
2.12 Office Equipment (Mainland)		0.02[0.02]			0.02[0.02]
2.13 Vehicles and Motor Cycles				0.07[0.07]	0.07[0.07]
3. CONSULTING SERVICES & TRAINING:					
3.1 Supervision of Construction Works Health Facilities			1.62[1.62]		1.62[1.62]
3.2 Zonal Training in Project Management				0.24[0.24]	0.24[0.24]
3.3 Training Health Workers in MCH and OBYS Care				1.84[1.84]	1.84[1.84]
3.4 Postgraduate Training of Tutors (M)				0.47[0.47]	0.47[0.47]
3.5 Postgraduate Training of Tutors (Z)				0.18[0.18]	0.18[0.18]
3.6 Training various Health Workers in Zanzibar				0.53[0.53]	0.53[0.53]
3.7 Training CHS Personnel				0.19[0.19]	0.19[0.19]
3.8 Technical Assistance (Tutors CHS, PHC needs etc)			0.76[0.76]		0.76[0.76]
3.9 Technical Assistance for PMU (Z)			0.60[0.60]		0.60[0.60]
3.10 Auditing firm yearly project accounts auditing (M)			0.08[0.08]		0.08[0.08]
3.11 Auditing firm yearly project accounts auditing (Z)			0.05[0.05]		0.05[0.05]
4. MISCELLANEOUS					
4.1 Operating Costs for PMU (Z)				0.92[0.92]	0.92[0.92]
4.2 Operating Costs for Coordination (M)				0.84[0.84]	0.84[0.84]
TOTAL	3.77[3.77]	32.61[28.16]	3.10[3.10]	4.96[4.96]	44.44[40.00]

*Shortlist applies to the use of consulting services only. **Other may be LIC, International or National Shopping Government Procedures or Direct Purchase. *** Figures in brackets [] are amounts financed by the ADF Loan.

Table 5.2
Other Modes of Procurement
(UA million)

Procedure	Goods	Max per Contract	Max in Aggregate
International Shopping	Ambulances	0.24	0.24
National Shopping	Vehicles and Motor Cycles	0.07	0.07
Direct Negotiations	Training in Project Management	0.08	0.24
	Training Health workers in OBYS	0.05	1.84
	Training Health Cadres Zanzibar	N/A	0.71
	Training CHS personnel	N/A	0.19
	Postgraduate training of tutors	0.03	0.47

Works

5.4.2 Procurement of civil works for rehabilitation and extension of health facilities (valued at UA 22.31 million in aggregate), rehabilitation and upgrading two training institutions (UA 2.10 million), extension of CHS in Zanzibar (UA 1.63 million), upgrading of 2nd line dispensaries (UA 3.70 million) and refurbishment of PMU offices in Zanzibar (UA 0.20 million) will be carried out through National Competitive Bidding (NCB). A minimum of seventeen such contracts, one for each district, will be awarded for rehabilitation and extension of health facilities on the Mainland.

Two contracts will be awarded for training institutions, while six others, one contract per facility, will be awarded for rehabilitation of 2nd line dispensaries in Zanzibar. The contracts for health facilities will be packaged per district or dispensary in order to create ownership under the decentralised system in Tanzania. NCB has been chosen given the fact that the character, location or size of the construction works to be undertaken are such that they are unlikely to attract bids from outside Tanzania, and there are local contractors sufficiently qualified and in numbers sufficient to ensure competitive bidding.

Goods

5.4.3 Biomedical equipment for health facilities (valued at 3.16 million in aggregate), radio and communication equipment (UA 0.61 million) will be procured through International Competitive Bidding.

5.4.4 Furniture for rehabilitated facilities (UA 1.51 million in aggregate), furniture and equipment for training institutions (UA 0.28 million), furniture and equipment for CHS (UA 0.17 million), furniture for 2nd line dispensaries (UA 0.13 million), equipment for 2nd line dispensaries (UA 0.20 million), teaching and learning materials (UA 0.08 million) and general office equipment (UA 0.30 million) will be procured through National Competitive Bidding. This mode is chosen as the individual contracts are of such value or quantities or character that their supply would not likely be of interest to suppliers from outside Tanzania and there are local suppliers sufficiently qualified and in sufficient number to ensure competitive bidding.

5.4.5 Ambulances for district hospitals, valued at UA 0.24 million, will be procured through International Shopping because they are standard specification commodities and cannot be purchased locally. Vehicles and motor cycles, valued at UA 0.07 million, and printing of job aids (UA 0.05 million) will be procured through National Shopping (NS), because the items are readily available off-the-shelf goods or standard specification commodities, which can be purchased locally.

Consulting Services

5.4.6 Professional services of a multi-discipline firm for supervision of the civil works, (valued at UA 1.62 million in aggregate), technical assistance for PMU in Zanzibar (0.60 million) technical assistance for annual audit of project accounts (UA 0.13 million) and PHC Training Needs Assessment, CHS Curriculum Review, CHS Sustainability Plan and Monitoring and Evaluation (valued at UA 0.76 million), will be procured through Short Listing. The selection procedures will be based on the technical quality with price consideration, except for audits, for which the selection procedure will be based on establishing the comparability of technical proposals and selection of the lowest financial offer.

Training

5.4.7 Zonal training in Project Management and Maintenance, (valued at UA 0.24 million), and training of health workers in MCH and Obstetric Care, (UA 1.84 million), will be procured, respectively, through direct negotiations with institutionally responsible departments of PMO–RALG and Reproductive and Child Health Section. The capacity, expertise, experience, and track record of these institutions have been found to be acceptable. The training of health cadres and CHS staff, and scholarships for Zanzibar students to study on the Mainland (valued at UA 1.37 million in aggregate) will be procured in accordance with existing MOHSW procedures acceptable to the Bank. All training plans and student placement proposals shall be subject to Bank review and approval. The PMU will submit training schedules and budgets, within two months of the start of each fiscal year, to the Bank for approval.

Miscellaneous

5.4.8 Operating Costs for coordination and management comprise travelling and subsistence allowances; the provision of office supplies; vehicle running costs; communication costs; travel allowances and other sundries/incidentals/supplies.

National Procedures and Regulations

5.4.9 Tender Procedures and Regulations from the Government of Tanzania have been reviewed and are found to be acceptable.

Executing Agency

5.4.10 The resources, capacity and expertise of the MOHSW on the Mainland are adequate to carry out procurement activities; however, in Zanzibar they are inadequate. Provision has been made for the recruitment of a Project-financed Procurement Specialist in the PMU for Zanzibar, in accordance with the Bank's Rules of Procedure for the Use of Consultants.

General Procurement Notice

5.4.11 The text of a General Procurement Notice (GPN) will be agreed upon with GOT during negotiations and will be issued for publication in the United Nations Development Business (UNDB), upon Loan approval by the Bank's Board of Directors.

Review Procedures

Prior Review

5.4.12 The following documents are subject for review and approval by the ADF before promulgation:

- Specific Procurement Notices (SPNs);
- Tender documents or Requests for Proposals from consultants;
- Lists, designs, specifications, tender documents with draft contract agreements for civil works, equipment and furniture for the health facilities;
- Tender evaluation reports including recommendations for contracts award;
- Draft contracts if these have been amended from the drafts included in the tender documents;
- Training plan for health cadres;
- Annual scholarship award plan; and
- Placement proposals for training and scholarship awards.

Post Review

5.4.13 Given the large number of contracts of small value, there will be procurement Post Review procedures for items below the following thresholds, viz.: UA 100,000 [for Works]; UA 50,000 [Goods]; and UA 30,000 [Consultancy].

5.5 Disbursement Arrangements

The direct payment method and the special account method will be used. In the Mainland the Borrower will open one Special Account (SA) in a bank acceptable to the ADF into which part of the ADF Loan resources will be deposited. It will also open two Local Currency Accounts (LCAs) in a bank acceptable to the ADF. One of the LCA will be used for the drawdown of ADF resources while the second will be for receiving counterpart funds. In Zanzibar the Borrower will open one Special Account (SA) in a bank acceptable to the ADF into which part of the ADF Loan resources will be deposited. It will also open one Local Currency Account (LCA) in a bank acceptable to the ADF. This account will be used for the drawdown of ADF resources. The ADF will replenish the SAs after the Executing Agencies have provided valid justifications for the use of

at least 50% of the preceding advance and after all previous advances have been fully justified. The opening of the SAs and the LCAs will be a condition precedent to first disbursement.

5.6 Monitoring and Evaluation

5.6.1 Monitoring and evaluation are central to achieving improved maternal and newborn health outcomes through gathering evidence and identifying the most efficient and effective interventions. In this regard, a Public Health Specialist/Monitoring and Evaluation Specialist will be seconded to the project from the Reproductive and Child Health Section. Resources have been provided for a short term consultant to prepare a monitoring and evaluation plan in close collaboration with the Reproductive Health Technical Working Group (paragraph 5.2.3). The plan will define appropriate indicators for monitoring reproductive health performance both in the project areas and nationally. Relevant data will be collected regularly by the community resource persons and facility staff in accordance with the guidelines provided. Data will be forwarded to the Monitoring and Evaluation Specialist who will prepare regular project progress reports for presentation to the Steering Committee. Selected process indicators for maternal and newborn health will be institutionalized in the HMIS.

5.6.2 The monitoring of maternal and newborn death will use process indicators as integrated in the draft National Road Map Action Plan to accelerate the reduction of maternal and newborn death. The recently completed Assessment of Emergency Obstetric Care Services in Tanzania will provide baseline information, which will be supplemented by support to operational research activities and small surveys as envisioned under the National Road Map. Monitoring of maternal and perinatal death will assist the country to capture maternal and newborn problems and deal with them at an early stage.

5.6.3 The Policy and Planning Division on the Mainland and the PMU in Zanzibar shall, within thirty (30) days following the end of each quarter, submit to the Bank a QPPR, in accordance with the established format, covering all aspects of the project including a summary of issues discussed during Steering Committee meetings. QPPRs will cover progress measured against indicators in the project matrix. The GOT will also collate and submit a Project Completion Report in accordance with the format recommended by the Bank. Additional reports and clarifications will be submitted to the Bank as and when required.

5.7 Financial Reporting and Auditing

In order to ensure efficient monitoring of project expenditures, the Planning Department on the Mainland and the PMU in Zanzibar will maintain separate project accounting records corresponding to the appraised budget and List of Goods and Services. Detailed accounts on Bank and Government expenditures should facilitate the identification of expenditure by component, category of expenditure and source of finance. The accounts should clearly document Bank and Government disbursements by category of expenditure and the status of any revolving funds. The accounts and ledgers will be kept separately from any other project. External auditors will audit the project accounts annually, and at the end of the project. An Audit Report will be presented annually to the Bank, within six (6) months following the end of each financial year. A budget has been included for the recruitment of auditors to prepare the required reports on time.

5.8 Aid Co-ordination

5.8.1 In Mainland Tanzania aid is coordinated at two levels namely, at the sectoral level and at the national level. In the health sector, the Policy Planning Division is responsible for coordinating donor assistance. On the donors' side, the Development Partners Group (DPG) on Health promotes

co-ordination among development partners. The DPG - Health promotes closer harmonization, collaboration and greater alignment between development assistance and national processes through joint missions, reviews, and analytical work. SWAps is the agreed operational modality for implementing health activities under the HSSP. DPG members meet on a monthly basis without the presence of government, in order to coordinate their views and activities. A SWAps Committee which meets twice a year provides a forum for effective policy consultations between the MOHSW and the PMORALG, Development Partners and other stakeholders. In addition, a Joint Annual Review Meeting is held to assess performance of the sector. Aid coordination in Zanzibar's health sector is weak and efforts are underway to strengthen it.

5.8.2 At the national level the Ministry of Finance is responsible for coordinating all external resources. The Tanzania Assistance Strategy (2002/03 - 2004/05), served as the medium-term framework for development co-operation, aiming to strengthen aid coordination, harmonisation and alignment as well as national ownership and Government leadership of the development process. In 2005/06 Mainland and Zanzibar prepared a Joint Assistance Strategy (JAS) as a national medium-term framework for managing development co-operation between the Government of Tanzania and Development Partners so as to achieve national development and poverty reduction goals. The JAS has been formulated in the spirit of national and international commitments and initiatives on aid effectiveness. TZFO will participate in both the Health Development Partner Group at the sector level and the main DPG at the national level.

6. PROJECT SUSTAINABILITY AND RISKS

6.1 Recurrent Costs

6.1.1 The project on the Mainland is being implemented within the overall framework of the Second Health Sector Strategic Plan which the Development Partners together with the Government have approved and in the MTEF, appropriate budget provisions will be made for recurrent costs. In this regard all recurrent costs, estimated at UA 0.80 million representing a 0.5% increase per year on the recurrent budget, which will arise as a result of recruitment of additional Assistant Medical Officers, provision of new equipment, rehabilitation and extension of health facilities and training institutions will be catered..

6.1.2 There are no major additional recurrent costs to be incurred through the human resource development of the health sector, as the project will not expand the existing staff establishment in Zanzibar. The project will assist the MOHSW in filling vacant posts, but will not create any new ones. Training of students from Zanzibar is intended to provide a pool of qualified candidates for vacancies that will occur in line with budgeted establishment growth. Training of professional health workers and in-service training for staff already in the public health sector will help improve the quality of service delivery and thus bring about economic efficiencies together with increased productivity.

6.1.3 The infrastructure development activities, comprising construction of new classrooms, dormitories and staff quarters at the CHS, 40 new double housing units, upgrading of second-line dispensaries, and refurbishment of the PMU offices and erection of 3 incinerators will increase recurrent costs in Zanzibar by UA 0.11 million per year. However, the MOHSW is in the process of finalizing the Health Sector Strategic Plan which will be costed and the necessary recurrent budget will be provided.

6.2 Project Sustainability

6.2.1 Capacity building is a key component of the project, which is expected to significantly enhance the sustainability of project benefits in a number of ways. Regular professional upgrading of skills for health personnel and improving the working environment will enhance productivity and improve staff retention. This would enhance the sustainability of the health facilities and ensure the provision of quality health services for the target population. In addition, cost sharing of training fees as well as post training bonding measures will be applied.

6.2.2 Provision of housing at Health Center on the Mainland and at PHC Units in Zanzibar will be done in order to attract appropriate staff to manage the facilities. A direct spin-off of this intervention is that the Health Centers on the Mainland and PHC facilities in Zanzibar will have somebody who can attend to emergencies 24 hours round the clock.

6.2.3 The Government is running a decentralized system on the Mainland and there is an on going programme to enhance infrastructure rehabilitation and maintenance using basket funds. According to the agreed guidelines between the government and development partners on resources allocation by type of expenditure, 10 - 20 % of the overall budget at health facility level should be reserved for minor rehabilitation and maintenance. This programme involves utilization of the Local Government throughout the project cycle starting right at facility level i.e. involving local communities. In this regard, the sustainability of the project is guaranteed through community involvement as they will be custodians of the facilities and responsible for maintenance.

6.2.4 Maintenance of new and rehabilitated facilities and equipment in Zanzibar has been enhanced by DANIDA's ongoing initiative in facilities and equipment maintenance. In addition, the training under the project of health workers in the correct use and maintenance of equipment will help preserve the expected life of equipment and training of facilities and equipment technicians in operating and maintenance procedures will also add to overall sustainability of project infrastructure.

6.3 Project Assumptions, Risks and Mitigating Measures

6.3.1 The project risks are summarized in the MPDE matrix and are as follows:

- (i) GOT fails to deploy all the trained staff;
- (ii) Communities are not committed to participating in training;
- (iii) Regions do not meet their commitments to implement new policies, protocols and guidelines;
- (iv) Regions do not ensure participation of their representatives in all the project processes; and
- (v) GOT's lack of commitment to implement the HSSP and the Road Map.

6.3.2 Concerning the first risk, the mitigation measure is that the GOT will ensure that positions in the establishment are created according to staffing norms. These positions will then be budgeted for in advance in line with the MTEF. Some of these positions are already existing but currently vacant or held by people who do not have the required qualifications. Thus as the newly qualified staff become available they should be deployed immediately.

6.3.3 As for the second risk, it is part of the project design to involve the relevant local authorities in the design and management of the project in order to ensure their support. This is in line with the principles of District Health Services in Tanzania where authority over health facilities is devolved to the Districts. Thus district authorities are involved in planning of all interventions in their areas.

6.3.4 With regard to the third risk the mitigation measure to be taken include the involvement of the Local Governments both at regional and district levels in project design, planning and implementation.

6.3.5 Regarding the fourth risk, the project includes community mobilization activities that will ensure that communities are informed and consulted about project activities and that appropriate IEC is developed to respond to community needs.

6.3.6 Concerning the fifth risk, Development Partners supporting the health sector endorsed the draft Road Map Action Plan to Accelerate the Reduction of Maternal and Newborn Deaths; and the MTEF which is used to implement the HSSP.

7. PROJECT BENEFITS

7.1 Socio-Economic Impact

7.1.1 This project is designed to reduce MMR through increased attention to provision of quality emergency obstetric care, and strengthened linkages between the community and the health care facility. This will entail having skilled attendance during pregnancy and childbirth, essential equipment and supplies as well as client focused service delivery that will save the lives of women and newborns at all levels. Given the fact that there are about 9,000 maternal deaths annually on the Mainland and the population in the project area is 12.5% of the total population, it can be assumed that about 1,125 deaths will be averted each year. Furthermore, since there are 20 disabilities for each maternal death, this means that about 22,500 disabilities will be averted in Mara, Mtwara and Tabora. This will have a significant social impact since most of the averted deaths and disabilities will be among young women. Averted maternal deaths and maternal disabilities will enable women to make effective contributions to their families and the community in general. By providing improved maternal health care services in under served areas the project will enhance equity and access to quality health services for the poorer segment of the population

7.1.2 Strengthening the interface between household and health facility through community participation will bring public awareness to the majority of the population in the project area whose exposure to maternal health is currently limited. This will also empower families and communities to make birth plans, to prepare for emergencies and to understand the importance of facility based deliveries for the well-being of women, children and thus the whole community. A special emphasis on involving husbands and community leaders in making sure that their wives deliver in health facilities will make it easier for women to make their own choices and to have a more powerful say in matters related to their health. Emphasis on client orientation and quality assurance at facility level and a greater interaction of health staff with communities as well as the better equipped and staffed facilities will also increase the trust communities place in the public health sector to provide them with appropriate care.

7.1.3 Maternal deaths also constrain economic development because of its negative impact on the family, the community and future generations. Based on a continent wide WHO/AFRO study (2000), the productivity losses of one case of maternal mortality are about USD 8,880 over one decade. Moreover, maternal disabilities which occur in the ratio of twenty disabilities for each maternal death result in productivity losses of USD 470 over one decade. For the social sector, it might be difficult to isolate the economic impact of reductions in maternal mortalities or morbidities that result from the project in the beneficiary areas. However, reaching the Government's target of reducing maternal mortality from 578 to 265 per 100,000 live births in the project areas should lead to annual productivity gains of about USD 5.4 million (excluding other any productivity gains from maternal disabilities or neonatal deaths averted).

8. CONCLUSIONS AND RECOMMENDATIONS

8.1 Conclusions

8.1.1 Factors underlying direct causes of maternal and newborn deaths operate at several levels and lack of access to and use of, essential obstetric services in particular is a crucial factor that is contributing to high maternal mortality. A significant reduction in newborn deaths can also be achieved with interventions designed to improve the health of the mother and her access to care during labour, birth, and the critical hours immediately afterwards. The project has been designed to scale-up appropriate maternal health care programmes by enhancing availability of skilled birth attendants and assuring pregnant women access to Emergency Obstetric Care (EmOC) in the event of obstetric complications. In addition, housing will be provided at the health centre level in Mainland and at the first line dispensaries in Zanzibar in order to ensure availability of staff in case of emergencies. This will also serve as an incentive toward retention of staff in rural areas.

8.1.2 The project is also expected to develop and implement a comprehensive training plan to ensure availability of staff at the right levels with the required competencies and in appropriate numbers to provide effective maternal health care. The institutional capacity of the CHS will be strengthened to enable it increase its output in line with the country's needs and improve the quality of its tutors and trainees. Institutional strengthening will include some physical expansion in line with the increased intake of students. Working closely with the World Health Organization and the Commonwealth Health Secretariat the teaching capacity at the College of Health Sciences in Zanzibar will be strengthened through recruitment of tutors from neighbouring countries.

8.1.3 The Project will have significant health and socio-economic impacts, as a result of: improved access to quality health care for rural populations in line with equity principles contained in the health sector reforms; increased utilization of health facilities for uncomplicated deliveries; improved maternal health; reduced severity of illnesses such as malaria as a result of improved access to care and treatment. In addition, socio-economic impacts include: savings for rural people who will not have to travel far in search of better health care and gains in productivity as a result of averted maternal deaths and disabilities. The Project is expected to benefit women to a large extent and will contribute to addressing gender disparities in health and access to opportunities.

8.2 Recommendations and Conditions for Loan Approval

It is recommended that an ADF loan not exceeding UA 40.00 million be granted to the Government of the United Republic of Tanzania for the purpose of implementing the project as described in this report. The loan is subject to the following particular conditions:

(a) Conditions Precedent to Entry into Force

The entry into force of the Loans Agreement shall be subject to the fulfillment by the Borrower of the provisions of Section 5.01 of the General conditions.

(b) Conditions Precedent to First Disbursement

The Borrower shall have, to the satisfaction of the Fund:

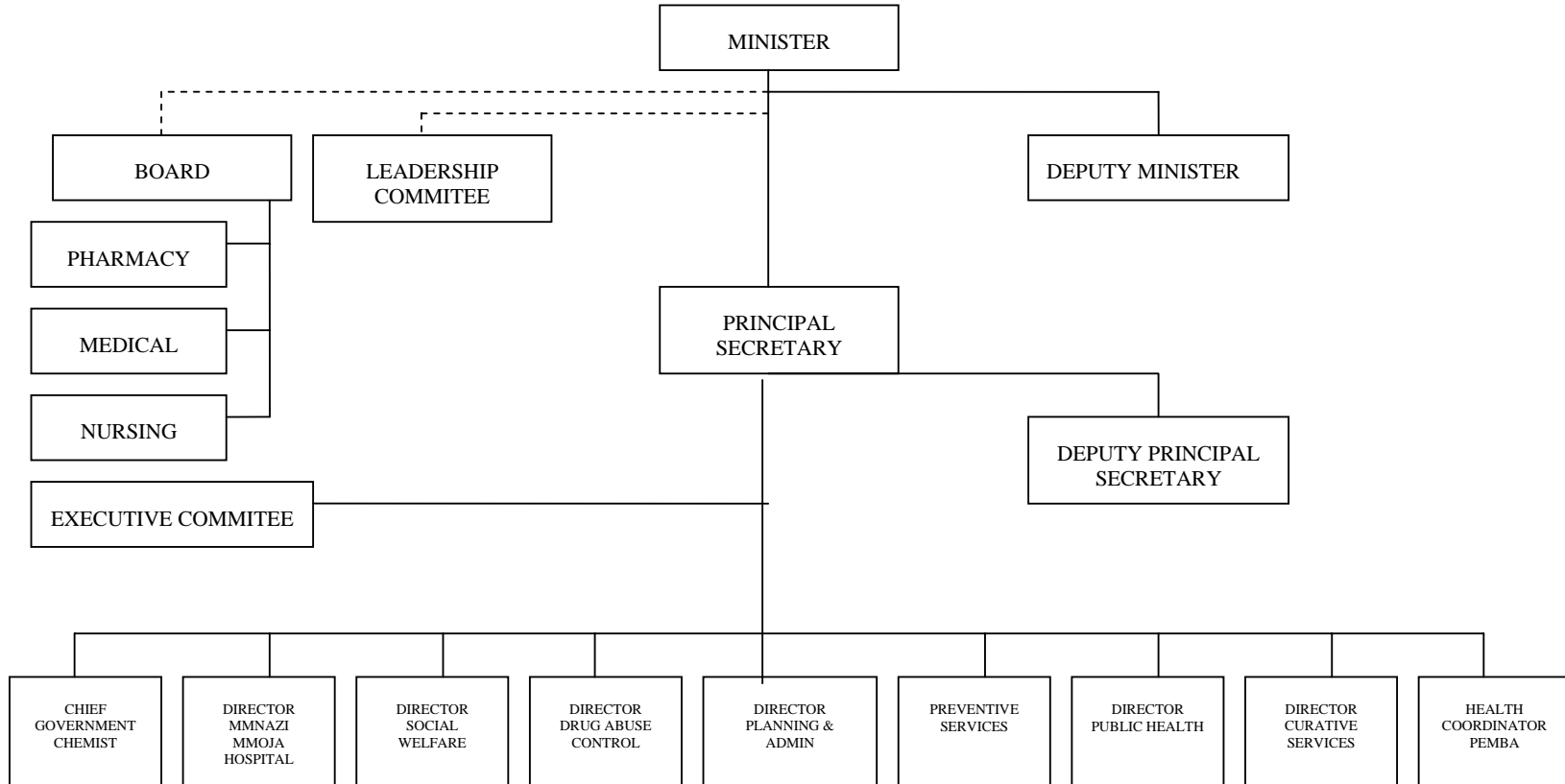
- (i) Provided evidence of having opened the following accounts in a bank(s) acceptable to the Fund: For the Mainland - one Special Account (in foreign currency) and one local currency Account into which the loan proceeds shall be deposited, and a separate local currency for deposit of the Borrower's counterpart funds; and, for Zanzibar – one Special Account (in foreign currency) and one local currency Account into which the loan proceeds shall be deposited (paragraph 5.5).

MAP OF TANZANIA

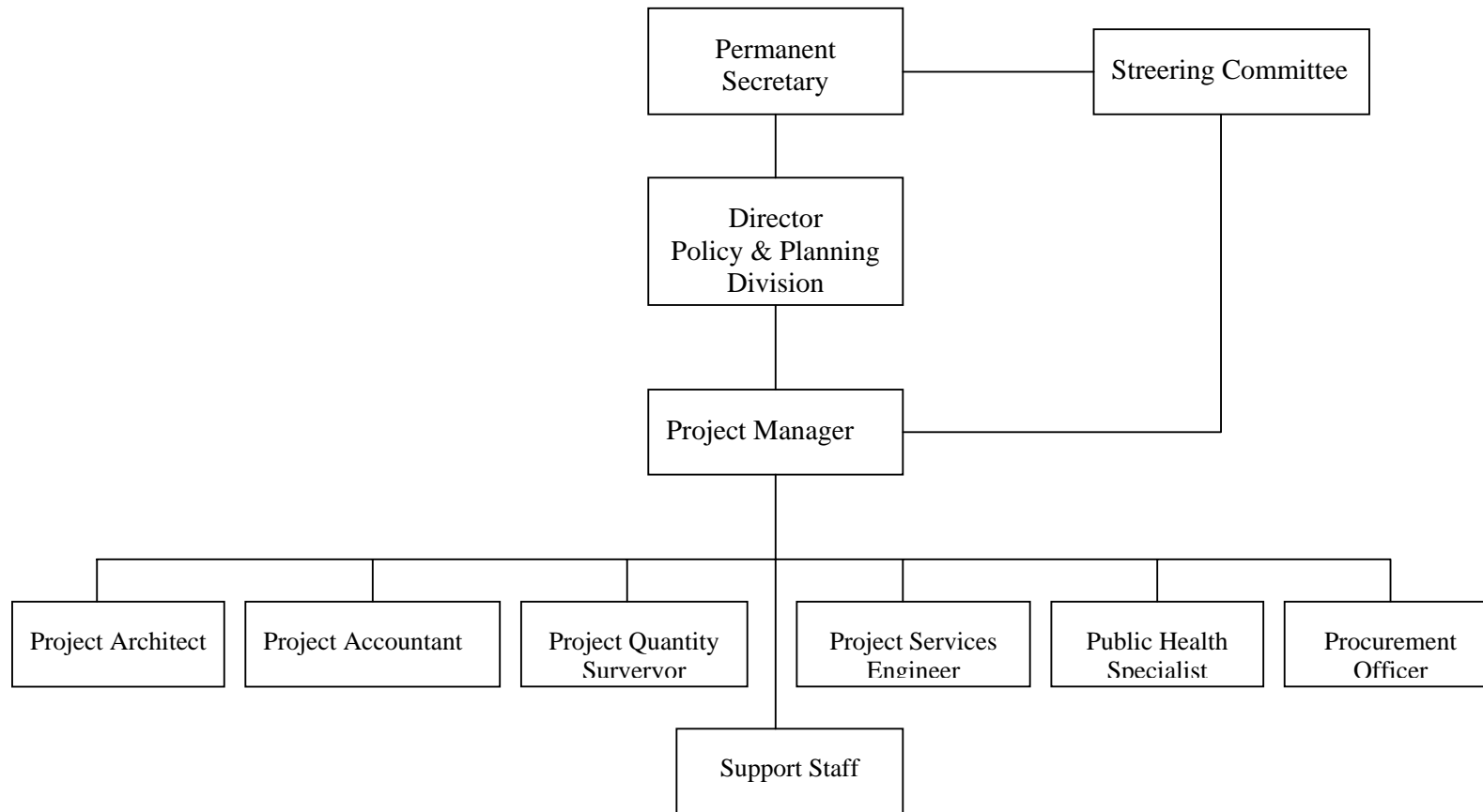


This map has been prepared by the ADB Group's staff exclusively for the convenience of the readers of the report to which it is attached. The denominations used and the boundaries shown on this map do not imply, on the part of the Group and its affiliates, any judgement on the legal suits of any territory or any endorsement or acceptance of such boundaries.

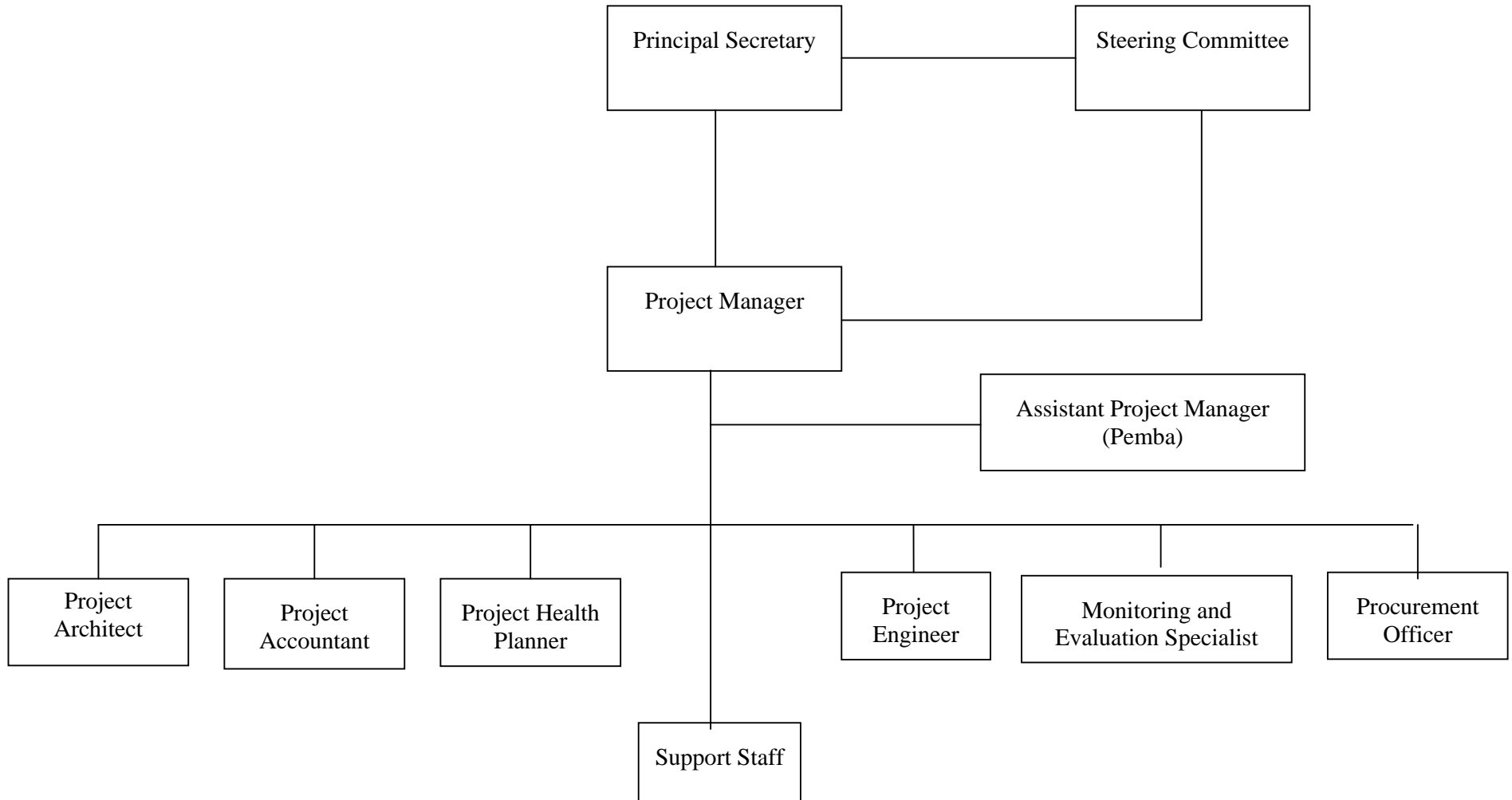
MINISTRY OF HEALTH AND SOCIAL WELFARE – ZANZIBAR: ORGANIZATION CHART



PROPOSED PROJECT MANAGEMENT UNIT (PMU) ORGANIZATION STRUCTURE (M)



PROPOSED PROJECT MANAGEMENT UNIT (PMU) ORGANIZATION STRUCTURE (ZANZIBAR)



SUMMARY LIST OF DONORS SUPPORTING REPRODUCTIVE HEALTH

	Organization	Area of support
National Level	UNFPA	FP, ARH, , SMI CPAC, CBD (Development of policy guides)
	WHO	ARH, PMTCT, SMI,IMCI, Newborn care
	UNICEF	ARH, PMTCT, SMI,IMCI
	USAID	FP, ARH, PMTCT, SMI , FANC, CPAC
	JICA	SMI, , PMTCT,
	AMREF	VVF, PMTCT, SMI,IMCI
	GTZ	FP, ARH, PMTCT, SMI , FANC, CPAC
	UMATI	Service provision
	District Level	UNFPA
WHO		Development of policy guidelines, standards and protocols Capacity building of service providers& supervisors
UNICEF		Capacity building of service providers& supervisors
USAID		Capacity building of service providers& supervisors
JICA		Equipment, supplies
AMREF		Capacity building of service providers& supervisors
GTZ		Capacity building of service providers& supervisors
Community Level	UNFPA	CBD, youth Peer educators, Community empowerment on SRH and rights
	GTZ	CBD, youth Peer educators
	UNICEF	Out reach services, VHW, Peer educators , Community Based MIS
	JICA	TBA,
	AMREF	Out reach services, CBD

TANZANIA: TOWARDS THE MILLENNIUM DEVELOPMENT GOALS (MDGs)

MDG	MDG Target	NSGRP Target
1. Eradicate extreme poverty and hunger	a. Reduce by half the proportion of people living on less than a dollar a day between 1990 and 2015	(i) Reduce proportion of rural population below the basic needs poverty line from 38.6 percent in 2000/01 to 24 percent in 2010 (ii) Reduce proportion of the urban population below the basic needs poverty line from 25.8% in 2000/01 to 12.9% in 2010
	b. Reduce by half the proportion of people who suffer from hunger between 1990 and 2015	(i) Reduce proportion of rural food poor from 27% in 2000/01 to 14% by 2010. (ii) Reduce the proportion of the urban food poor from 13.2% in 2000/01 to 6.6% by 2010. (iii) Reduce prevalence of stunting in under fives from 43.8 % in 2002 to 20% in 2010 (iv) Reduce prevalence of wasting in under fives from 5.4% in 2002 to 2 % in 2010
2. Achieve universal primary education	Ensure that all boys and girls complete a full course of primary schooling	Increase primary net enrolment from 90.5% in 2002 to 99% in 2010
3. Promote gender equality and empower women	Achieve gender equality in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015	Achieve gender equality in primary, secondary and tertiary education by 2010
4. Reduce child mortality	Reduce by two thirds, between 1990 and 2015, the under-five mortality rate	(i) Reduce child (under-five) mortality from 154 per 1000 live births in 2002 to 79 in 2010 (ii) Reduce infant mortality from 95 per 1000 live births in 2002 to 50 in 2010
5. Improve maternal health	Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio	(i) Reduce maternal mortality by half from 529 per 100,000 in 1994 to 265 per 100,000 by 2010 (ii) Increase births attended by a skilled health worker from 50% to 80% by 2010.
6. Combat HIV/AIDS, malaria, and other diseases	a. Have halted by 2015 and began to reverse the spread of HIV/AIDS	(i) Reduce HIV prevalence from 11% in 2004 to 5% in 2010 between ages of 15-24 years (ii) Reduce HIV prevalence among 15-24 year old pregnant women from 11% to 5%

MDG	MDG Target	NSGRP Target
	b. Have halved by 2015 and began to reverse the incidence of malaria and other major diseases	<p>(i) Reduce cholera out-breaks by half by 2010</p> <p>(ii) Reduce hospital-based malaria-related mortality amongst under fives from 12% in 2002 to 8% in 2010</p>
7. Ensure environmental sustainability	a. Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources	<p>(i) Increase contribution of solar, wind and biomass and coal for electricity generation from 0.5% in 2003 to 3% percent by June 2010</p> <p>(ii) At least 10% of the population using alternatives to wood fuels for cooking by 2010</p>
	b. Halve, by 2015, the proportion of people without sustainable access to safe drinking water and sanitation	<p>(i) Increase proportion of rural population with access to clean and safe water (within 30 minutes of time spent on collection of water) from 53% in 2003 to 65% by 2009/10.</p> <p>(ii) Increase urban population with access to clean and safe water from 73% in 2003 to 90% by 2009/10.</p> <p>(iii) Increase access to improved sewerage facilities from 17% in 2003 to 30% in 2010 in respective urban areas.</p> <p>(iv) 95% of people with access to basic sanitation by 2010.</p>
	c. Have achieved, by 2020, a significant improvement of the lives of at least 100 million slum dwellers	<p>(i) Put in place planned and serviced urban settlements with functioning town planning procedures</p> <p>(ii) Reduce households living in slums without adequate basic essential utilities.</p> <p>(iii) Increase number of people having secure tenure of land and properties</p>

ANNEX VII

PROVISIONAL LIST OF GOODS AND SERVICES

CATEGORY	USD (mill.)			UA (mill.)			CO-FINANCIERS (UA mill.)	
	F.E.	L.C.	TOT	F.E.	L.C.	TOT	ADF LOAN	GOV
<i>Goods:</i>								
Furniture for rehabilitated facilities (Mainland)	0.795	1.193	1.988	0.538	0.806	1.344	1.344	
Biomedical Equipment for Facilities (Mainland)	3.328	0.832	4.160	2.250	0.562	2.812	2.812	
Radio Communication Equipment	0.640	0.160	0.800	0.433	0.108	0.541	0.541	
Ambulances, Vehicles and Motor Cycles	0.256	0.064	0.320	0.173	0.043	0.216	0.216	
Printing Job Aids	0.012	0.018	0.030	0.008	0.012	0.020	0.020	
Furniture and Equipment Training Institutions (Mainland)	0.288	0.072	0.360	0.195	0.049	0.243	0.243	
Teaching and Learning Materials (Mainland)	0.080	0.020	0.100	0.054	0.014	0.068	0.068	
Furniture and Equipment for CHS	0.225	0.000	0.225	0.152	0.000	0.152	0.152	
Furniture for 2nd Line Dispensaries (Zanzibar)	0.101	0.067	0.168	0.068	0.045	0.114	0.114	
Equipment for 2nd line Dispensaries (Zanzibar)	0.240	0.020	0.260	0.162	0.014	0.176	0.176	
Office Equipment (Zanzibar)	0.117	0.250	0.367	0.079	0.169	0.248	0.248	
Office Equipment (Mainland)	0.032	0.000	0.032	0.021	0.000	0.021	0.021	
Vehicles and Motor Cycles	0.098	0.000	0.098	0.066	0.000	0.066	0.066	
<i>Works:</i>								
Rehabilitation and Extension Health Facilities (Mainland)	16.802	11.202	28.004	11.358	7.572	18.930	16.120	2.810
Rehabilitation of two Training Institutions (Mainland)	0.510	2.040	2.550	0.345	1.379	1.724	1.468	0.256
Extension of CHS and Incinerators (Zanzibar)	1.584	0.396	1.980	1.071	0.268	1.338	1.338	
Upgrading of 2nd line Dispensaries, Housing Units and MHU	3.716	0.929	4.645	2.512	0.628	3.140	3.140	
Refurbishment of PMU Offices (Zanzibar)	0.200	0.050	0.250	0.135	0.034	0.169	0.169	
<i>Services:</i>								
Supervision of Construction Works Health Facilities	1.176	0.784	1.960	0.795	0.530	1.325	1.325	
Zonal Training in Project Management	0.120	0.180	0.300	0.081	0.122	0.203	0.203	
Training Health Workers in MCH and OBYS Care	0.000	2.415	2.415	0.000	1.632	1.632	1.632	
Postgraduate Training of Tutors (Mainland)	0.000	0.600	0.600	0.000	0.406	0.406	0.406	
Training various Health Workers including Tutors (Zanzibar)	0.302	0.596	0.898	0.204	0.403	0.607	0.607	
Training CHS Personnel	0.096	0.144	0.240	0.065	0.097	0.162	0.162	
Technical Assistance (Tutors CHS, PHC needs etc)	0.437	0.528	0.965	0.295	0.357	0.652	0.652	
Technical Assistance for PMU (Zanzibar)	0.762	0.000	0.762	0.515	0.000	0.515	0.515	
Auditing firm for yearly project accounts auditing (Mainland)	0.040	0.060	0.100	0.027	0.041	0.068	0.068	
Auditing firm for yearly project accounts auditing (Zanzibar)	0.060	0.000	0.060	0.041	0.000	0.041	0.041	
<i>Operating Costs:</i>								
Coordination and Management Zanzibar	0.228	0.179	0.407	0.154	0.121	0.275	0.275	
Coordination and Management Mainland	0.215	0.852	1.067	0.145	0.576	0.721	0.721	
Base Cost	32.460	23.650	56.110	21.942	15.986	37.928	34.862	3.066
Physical Contingencies	2.830	1.954	4.784	1.913	1.321	3.234	2.969	0.261
Price Contingencies	2.746	2.107	4.853	1.856	1.424	3.280	2.163	1.117
Total Cost	38.036	27.711	65.747	25.711	18.732	44.442	40.000	4.444

ENVIRONMENTAL AND SOCIAL MANAGEMENT PLAN SUMMARY

Project Title: Support to the Health Sector Strategic Plan to Accelerate the Reduction of Maternal and Newborn Deaths

Project No.: Country: Tanzania
Department: OSHD Division: OSHD.3

Brief description of the Project and key environmental and social components:

- Upgrading existing PHC facilities and training institutions (provide high quality new and rehabilitated facilities, whilst maintaining historical buildings and grounds).
- Procurement of biomedical equipment for PHC facilities.
- In-service training for numerous health professionals (improved healthcare throughout the country).

Major environmental and social impacts:

- Renovation and construction at the existing sites will affect the existing grounds leading to devegetation, soil erosion, formation of gullies, dust emission and noise
- Normal PHC facilities functions will generate potentially dangerous medical and other waste.

Enhancement and mitigation program:

- There will be re-vegetation after construction works and construction of appropriate drainage systems.
- During construction, contractors will preserve natural elements on site and limit disturbances (dust, noise etc) in the perimeter by fencing off work areas.
- Provision of incinerators at existing PHC facilities will provide for proper disposal of medical waste.

Monitoring program and complementary initiatives:

- The Local Governments (LG) and PMU will ensure that construction tender documents safeguard all buildings, and that the existing landscaped grounds are protected and enhanced.

Institutional arrangements and capacity building requirements:

- The LG and PMU, guided by a broad-based Steering Committee, will direct all consultants to adhere to guidelines designed to safeguard and improve physical environments.

Public consultations and disclosure requirements:

- The LG and PMU will from time to time, at the behest of the Steering Committee, offer public fora to publicize Project activities.

Estimated costs: Project environmental components:

- The major environmental improvement falls under the civil works for rehabilitation and extension of PHC facilities as well as training institutions and erection of incinerators with a budget of UA 27.73 million.
- Notably, medical waste management will be improved through the provision of incinerators at three PHC facilities in Pemba
- *Implementation schedule and reporting:*
 - Any items pertinent to environmental and social management planning adhere to the overall implementation schedule provided in *Annex VI*.

CONTENTS OF THE PROJECT IMPLEMENTATION DOCUMENT

1 THE PROJECT

- 1.1 Project scope and objectives
- 1.2 Project outputs

2 PROJECT DESCRIPTION

- 2.2 Project cost & financing

3 PROJECT IMPLEMENTATION

- 3.1 Executing agency
- 3.2 Institutional arrangements
- 3.3 Implementation plan
- 3.4 Procurement arrangements
- 3.5 National procedures and regulations
- 3.6 General procurement notice
- 3.7 Review procedures
- 3.8 Disbursement arrangements

4 MONITORING AND EVALUATION

- 4.1 Project reporting
- 4.2 Financial reporting and auditing

- Annex 1 Implementation Schedule
- Annex 2 Structure of Project Management Unit
- Annex 3 Job Description of key Staff
- Annex 4 List of Equipment
- Annex 5 List of PHC Facilities
- Annex 6 Project Matrix
- Annex 7 Project Detailed Costs

PROJECT PROCESSING SCHEDULE

	ACTIVITY	DATE
1.	Project Identification	2004
2.	Project Preparation Mission	April 2006
4.	Project Appraisal Mission	June/July 2006
5.	Internal Working Group (IWG) Meeting	14 July 2006
6.	Inter-Departmental Working Group Meeting	24 July 2006
7.	Loans Committee Meeting	7 August 2007
8.	Loan Negotiations	24 – 25 August 2006
9.	Submission of Document for Translation	30 August 2006
10.	Distribution to the Board	20 September 2006
11.	Posting of ESMP to ADB Website	11 September 2006
12.	Board Presentation	11 October 2006

ON GOING OPERATIONS AS AT 30 APRIL 2006

	SECTOR/PROJECT TITLE	FUNDS SOURCES	DATE APPROVED	AMNT (UA Mill.)	DATE SIGNED	DATE EFFECTIVE	AMNT DISB.	PER CENT DISB	DEADLINE FINAL DISB	AUDIT Report 04/05 SUBMITTED
	AGRICULTURE									
1	Agric. Marketing Systems Dev. Programme	ADF	18-Sep-2002	15.90	12 May. 2003	15 Dec. 2003	2.50	15.72	31.12.2008	Yes
		ADF- G	18-Sep-2002	1.00	12 May. 2003	15 Dec. 2003	0.42	42.00	31.12.2008	Yes
2	District Agricultural Sector Investment Project	ADF	24-Nov-2004	36.00	11-Feb-2005	20-Jul-2005	0.09	0.25	30.06.2012	Not Due
		ADF- G	24-Nov-2004	7.00	11-Feb-2005	20-Jul-2005	0.04	0.57	30.06.2012	Not Due
	SUB-TOTAL			59.90			3.05	5.09		
	TRANSPORT									
3	Road Rehabilitation / Upg. Project	ADF	03 Sep. 2001	38.65	28 Sep. 2001	6-Jun-2003	10.74	27.79	31.03.07	Yes
4	Zanzibar Roads Upgrading Project	ADF	24-Jun-2004	16.22	24-Jun-2004	5-Oct-2004	0.00	0.00	31.12.07	Not Due
		ADF- G	24-Jun-2004	0.71	24-Jun-2004		0.00	0.00	31.12.07	Not Due
	SUB-TOTAL			55.58			10.74	19.32		
	PUBLIC UTILITIES									
5	Dar es Salaam Water Supply	ADF	17 Dec 2001	36.94	29 May 2002	19 Nov. 2003	5.89	15.94	31.12.07	Yes
		ADF- G	17 Dec 2001	1.31	29 May 2002	19 Nov. 2003	0.57	43.51	31.12.07	Yes
6	Monduli Rural District Water Project	ADF- G	27 Nov 2003	15.51	10 Feb 2004	14Jul y 2004	3.45	22.24	31.12.08	Yes
	SUB-TOTAL			53.76			9.91	18.43		
	SOCIAL									
7	First Health Rehabilitation Project	ADF	03 Dec. 1997	15.00	08 May 1998	10 Sep. 1999	8.93	59.53	30.06.07	Yes
8	Education II Project	ADF	10 Dec. 1997	20.00	08 May 1998	06 Jan. 1999	16.81	84.05	30.06.06	Yes
9	Small Enterprises Loan Facility	ADF	11 Nov. 1998	8.00	12 Apr. 1998	29 July 1999	7.31	91.38	31.01.07	Yes
10	Three Regions Health Studies	ADF- G	14 July 1999	1.75	19 Nov. 1999	6-Apr-2001	0.98	56.00	31.01.06	Yes
11	Alternative Learning & Skills Dev. Project	ADF	31 Oct 2000	5.56	30-Jan-2001	24-Dec-2001	1.11	19.96	30.06.07	Yes
		ADF- G	31 Oct 2000	1.01	30-Jan-2001	24-Dec-2001	0.61	60.40	30.06.07	Yes
12	SAP for Vocational Ed & Training	ADF	09 July 2003	14.22	15-Sep-2003	16-Feb-2004	0.11	0.77	31.12.08	Not Yet
		ADF- G	09 July 2003	1.60	15-Sep-2003	16-Feb-2004	0.00	0.00	31.12.08	Not Yet
	SUB-TOTAL			67.14			35.86	53.41		
	MULTI-SECTOR									
13	Institutional Support for Good Governance	ADF-G	13 Dec 2004	4.8	11-Feb-2005	11-Feb-2005	0.00	0.00	31.12.08	Not Due
	SUB-TOTAL			4.80						
	GRAND TOTAL			236.38			59.56	25.20		

