

Findings

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Good Practice
Infobrief



Findings Infobriefs reports on Good Practice in ongoing operational, economic and sector work carried out by the World Bank and its member governments in the Africa Region. It is published monthly by the Knowledge and Learning Center on behalf of the Region. The views expressed in Findings are those of the author/s and should not be attributed to the World Bank Group.

Tanzania: The Health and Nutrition Project

The objectives of this project (assisted by an IDA credit of US\$ 47.6 million), which began implementation in 1990 and was closed in 1999, were to raise the quality, coverage and effectiveness of family planning, nutrition and basic health services through the provision of support to critical and strategic elements of the Health, Nutrition and Population (HNP) sector. While the component on Strengthening National PHN Systems was based in the Ministry of Health, the component on Strengthening Rural Primary Health Care had ten focus districts, and the component on Strengthening Urban Primary Health Care focused on three districts. This was the first IDA-financed health project in Tanzania.

The project suffered from poor quality at entry, with ambitious objectives, complex design and implementation arrangements, and ill-considered covenants and cross-conditionalities between different implementing agencies. Combined with the government's weak ownership at the outset and poor project management (in part due to the lack of previous IDA experience), project performance during the first three years was very poor. A mid-term review in 1994, and subsequent project restructuring in 1996, resulted in clearer project direction, more feasible workplans and more streamlined implementation. By the end of the project, the government assumed full and strong ownership of the project, and planned activities were completed with project objectives largely achieved. Moreover, the project initiated some of the key reform agenda, and supported the government in taking the leadership in sector-wide planning and donor co-ordination, paving the way for a multidonor-supported health sector reform program which the follow-on IDA credit is supporting.

Impact on the ground

- The project's impact on sector policies (in health financing and pharmaceuticals) were substantial: the government laid the foundations for more sustainable financing and pluralistic delivery of health services The project influenced important shifts in health financing policy, including the adoption of cost-sharing mechanisms and community financing schemes, and the reforms in drug policy and financing by establishing and fully capitalizing a semi-autonomous pharmaceutical agency. With DANIDA collaboration, the project made a significant impact with regard to improved systems and management in drug procurement and management, with a high potential for financial sustainability.. The evidence suggests that access to care improved in the project areas and that quality was enhanced with more reliable drug supplies and rehabilitated and equipped facilities.
- The government's annual allocation to the health sector almost doubled in the nine years of the project, partly due to project covenants (from 6-7 percent in the late 1980s to 12 percent in 1998/99).

- A micronutrient surveillance system (twenty-five sentinel centers) was set up which generates semestral indicators on nutritional status. Guidelines were developed and distributed and an Information, Education and Communication campaign was initiated on micronutrient deficiency programs.
- With regard to primary health care, all of the ten focus districts produced district health plans that have received funding for implementation. Overall, reports indicate that communities that actually participated in planning and rehabilitating primary health facilities have a clear sense of ownership; health infrastructure that relied partly on village funds also appear to be better maintained.
- The project piloted drug revolving funds for hospitals in twenty-three districts out of a total of 114 and Community Health Funds (CHF) in ten districts. A 1999 survey found that drug availability had improved significantly in CHF facilities, compared to 1996.
- Project training inputs were substantial and have borne fruit in terms of stronger planning capacity at the central Ministry of Health (MOH) and better management by District Medical Officers. Most of the project-trained government personnel were still in civil service at end-1999. This resulted in improved planning capacity and more satisfactory policy and technical discussions at the MOH and in the ten focus districts compared to the situation at project inception.

Lessons learned

- Project preparation should take account of project risks as comprehensively as possible and should reduce the complexity and extent of the project commensurately. Key risks here would be government ownership of project, sector leadership, management and technical capacity, and the extent and pace of the reform program.
- Cash-strapped poor countries often find themselves with little countervailing power in dealing with donors such as the Bank. The Bank, recognizing this, should avoid exploiting this vulnerability by imposing too many conditionalities, as these also may be detrimental to implementation.
- The benefits of an inter-ministry project must be weighed carefully against the costs of co-ordination. The separation of implementation responsibilities inhibits accountability and often leads to delayed and uncoordinated implementation.
- Critical policy reforms should be pursued as project outcomes rather than up-front conditionalities. Some conditions should be used for negotiation, some are better suited for project effectiveness, and others can be applied for funds disbursement.
- If it is beyond the control of the implementing agency to ensure compliance with the conditionality/ies, the Bank needs to recognize this early and not persist on inclusion; or it should assign responsibility for compliance where appropriate.
- Project components need to be synergistic and mutually reinforcing—they should not be used simply as “baskets” for funding activities.
- Analytical and policy work regarding macroeconomic and sector reforms needs to be carried out in a mutually supportive manner.
- Data gathering pertaining to baseline data and performance targets should be an intrinsic part of the project—their absence inhibits supervision and makes impact evaluation virtually impossible.
- Early training is critical for skill-scarce countries; procurement should be made a central concern of project management.
- Counterpart funds should be calculated globally for the whole project rather than on a contract-by-contract basis, and should take into account extra-budgetary resources generated from project-supported initiatives such as user fees from cost recovery programs and community inputs into village health initiatives.

This Infobrief has been excerpted with a few editorial modifications from Implementation Completion Report No. 19664 and from the Evaluation Summary produced by the Operations Evaluation Department. Further information can be obtained from Chiyo Kanda : Ckanda@worldbank.org or Timothy Johnston : Tjohnston@worldbank.org

*Persons accessing the Bank's External Website can access information on **Health, Nutrition and Population** by clicking on **Topics and Sectors**, then **Health, Nutrition, and Population**. World Bank staff can access the necessary information by clicking on **Sectors** and then on **Health, Nutrition and Population**.*