Project Information Document (PID)

Appraisal Stage | Date Prepared/Updated: 25-May-2023 | Report No: PIDA36196

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Project Name	Parent Project ID (if any)
Zimbabwe	P180160	Zimbabwe COVID-19 Response and Essential Health Services Additional Financing	P176141
Parent Project Name	**Region**	**Estimated Appraisal Date**	**Estimated Board Date**
Zimbabwe COVID-19 Emergency Response Project	EASTERN AND SOUTHERN AFRICA	22-May-2023	29-Jun-2023
Practice Area (Lead)	**Financing Instrument**	**Borrower(s)**	**Implementing Agency**
Health, Nutrition & Population	Investment Project Financing	Republic of Zimbabwe	CORDAID

Proposed Development Objective(s) Parent

To support the Government of Zimbabwe to deploy and manage COVID-19 vaccines and strengthen related health system capacity.

Proposed Development Objective(s) Additional Financing

To support the Government of Zimbabwe to deploy and manage COVID-19 vaccines and strengthen related health system capacity for pandemic preparedness and deliver essential health services, particularly RMNCAH

Components

Vaccine Deployment and Related Risk Communication and Community Engagement
Climate Friendly Related Health System Strengthening
Sustaining Essential Health Services
Overall Response Coordination and Project Management, Monitoring and Evaluation

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	15.00
Total Financing	15.00
of which IBRD/IDA	0.00
Financing Gap	0.00

DETAILS

Non-World Bank Group Financing

Trust Funds	15.00
Global Financing Facility	15.00

Environmental and Social Risk Classification

Substantial

Other Decision (as needed)

B. Introduction and Context

Country Context

1. **Zimbabwe is a landlocked, lower-middle-income[1] country with a gross national income per capita of US$1,530 (World Development Indicators [WDI], Atlas method for 2021) and a population of 15.9 million (WDI, 2021).** Zimbabwe has a population density of 40 persons per square kilometer. Its population is young: 41 percent are below 15 years old while four percent are aged 65 years and above. Women account for 52 percent of the total population. Approximately 67 percent of the population live in rural areas.

2. **Measures taken by the GOZ since 2020 to mitigate the impact of COVID-19 and resulting lockdowns eventually contributed toward stabilizing the economy, although further improvements would significantly depend on how the pandemic and global economic situation evolve**. Inflation in Zimbabwe peaked in 2020, reaching more than 550 percent. Annual inflation returned to triple digits in May 2022 and reached 244% in December 2022. However, monetary tightening, including sharp hikes in interest rates, and fiscal policy measures brought inflation down to 230% in January 2023. Real Gross Domestic Product (GDP) is estimated to have slowed to 3.4% in 2022 from 8.5% in 2021. Extreme poverty has declined since its peak in 2020. However, due to persistent inflation, high dependence on low-productivity agriculture, slow structural transformation, and intermittent shocks like drought, natural disasters, and the COVID-19 pandemic have contributed to the high rate of poverty and vulnerability in Zimbabwe.[2]

Sectoral and Institutional Context

3. **Prior to the COVID-19 pandemic, Zimbabwe's progress in improving health outcomes and**

[1] In 2018, the Government rebased GDP and Gross Domestic Income figures which changed its economic status from low-income to lower-middle income.
[2] https://www.worldbank.org/en/country/zimbabwe/overview

expenditure efficiency has been mixed. Zimbabwe's human capital index (HCI) increased from 0.41 in 2010 to 0.47 in 2020. Its HCI index is higher than the Sub-Saharan African 2020 average (0.20) but is slightly lower than the average (0.48) for lower-middle income countries.[3] Zimbabwe's Maternal Mortality Ratio, a key indicator of the nation's health system status, decreased from 651 in 2015 (ZDHS) to 462 maternal deaths per 100,000 live births (Multiple Indicator Cluster Survey [MICS] 2019) but remains high and ranks lower compared to its regional peers. Under-five mortality also decreased but remains high at 78 per 1,000 live births (MICS 2019). HIV and tuberculosis (TB) prevalence has also declined. While underweight in under-five children increased from 8.4 percent in 2015 (Demographic Health Survey/DHS 2015) to 9.7 percent in 2019, stunting in under-five children decreased from 26.8 percent in 2015 (DHS) to 23.5 percent in 2019 (MICS 2019). However, neonatal mortality has remained at 32 per 1,000 live births since 2009 (MICS 2019). Government Health Expenditures (GHE) increased from US$523 million in 2015 to US$963 million in 2018 but declined to US$301 million in 2019 and US$222 million in 2020. In addition, GHE as a share of GDP decreased from 2.6 percent in 2015 to 1.9 percent in 2019; provisional data from the Ministry of Finance and Economic Development's (MOFED) 2021-2023 Macroeconomic Fiscal Framework suggests it may have fallen to 1.1 percent in 2020 although this would need to be interpreted with caution.[4] The draft Health Public Expenditure Review (WB 2021) notes that the major reduction in GHE in absolute terms in 2019 resulted mainly from inflation as opposed to a de-prioritization of the health sector. In view of its overall tight fiscal space, Zimbabwe could undertake certain measures to improve efficiency of its current health spending such as strengthening monitoring and evaluation (M&E) and internal audits, reducing fragmentation including aligning different Government plans for human resources in health management, and establishing transparent resource allocation criteria.

4. **The COVID-19 outbreak further undermined gains made in service delivery that had started to decline around mid-2019 due to inflation and climatic shocks.** Economic and climatic shocks and Cyclone Idai contributed to increasing inflation and foreign currency shortages**.** The COVID-19 pandemic further affected service delivery due to the national lockdowns and related social distancing restrictions to minimize the risk of COVID-19 transmission. While results-based financing in the health sector helped cushion inflation's impact, the decrease in real value of salaries and reported personal protective equipment shortages have led to doctors and nurses' strikes and/or absences. The mini-Poverty, Income, Consumption and Expenditure Surveys (PICES) conducted in 2019 and 2020 showed a decrease in rural dwellers who sought treatment from 81 percent to 71 percent although more urban dwellers sought treatment (77 percent to 83 percent). In addition, the share of persons not seeking treatment due to lack of funds increased in both rural (from 62 percent to 90 percent) and urban (from 70 percent to 93 percent) areas. Data from a sample of health facilities indicate reductions in several reproductive, maternal, and child health and nutrition services (e.g., antenatal care, postnatal care, institutional deliveries, family planning and growth monitoring) and indicators (e.g., institutional maternal deaths and home deliveries) that worsened since 2018 in selected health facilities.

5. The health sector is yet to fully recover from the impact of COVID-19 despite some notable progress in some key service coverage indicators. For example, the indicator on the number of women

[3]WB Zimbabwe HCI Brief 2020

[4] Caution should be taken in interpreting provisional and incomplete spending data for 2020. In addition, MOFED clarified that the nature of the pandemic entailed that an important share of health spending was managed outside of the MOHCC during 2020. For example, the Ministry of Local Government managed COVID isolation centers and upgrading of health facilities in 2020.

visiting health centers for four or more antenatal care visits (ANC4+) has been on the rebound but performance in 2022 was still below the pre-pandemic levels. Institutional maternal mortality increased in 2020 to 103 deaths per 100,000 births, with a subsequent further increase to 122/100,000 in 2021 before declining in 2022 to 107/100,000.

C. Proposed Development Objective(s)

Original PDO

6. To support the Government of Zimbabwe to deploy and manage COVID-19 vaccines and strengthen related health system capacity.

Current PDO

7. To support the Government of Zimbabwe to deploy and manage COVID-19 vaccines and strengthen related health system capacity for pandemic preparedness and deliver essential health services, particularly RMNCAH

Key Results

8. To monitor the implementation of EHS activities, one PDO indicator (PDOI) and four intermediate results indicators (IRIs) are proposed to be added to the results framework. These are:

- Percentage of children under 5 years that are fully immunized (PDOI)
- Percentage of health facilities reporting no stock-out of essential tracer medicines and medical supplies in the last quarter (IRI)
- Number of people who received community outreach services (IRI)
- Number of village health workers trained in the expanded community health service package (IRI)
- Number of maternity waiting homes refurbished and fully functional (IRI)

9. Revised indicators and targets: With the availability of more accurate data, the baseline and endline targets are revised for the IRI, Number of primary health care facilities with solar for health system. The end target date for all existing indicators is revised to match the new project closing date.

D. Project Description

10. Components 1 and 2 remain unchanged. A new component for the activities financed by the proposed AF is added as Component 3, and Component 3 under the parent project is changed to Component 4.

11. **Component 3: Sustaining Essential Health Services**. This is a new component that will support the continuity of EHS. The proposed activities to be financed under this component are:

12. **Subcomponent 3.1: Integrated Outreach Service Delivery**. This subcomponent will support the provision of a comprehensive package of essential health services including immunization, antenatal and postnatal care to communities without access to health facilities.

Subcomponent 3.2: Strengthening Community Health Services including Disease Surveillance. This sub-component will finance training, mentorship and strengthening the supervision of village health workers and some commodities, as well investments in transportation for the first level of care.

13. **Subcomponent 3.3: Commodity Security**. This sub-component will finance procurement of family planning commodities to bridge gaps not financed by the government and other donors. It will also invest in key inputs for reproductive, maternal and newborn and adolescent health (RMNCAH).

14. **Subcomponent 3.4: Revitalization of Maternity Waiting Homes (MWHs)**. This sub-component will support the revitalization and improvement of quality of services provided in the MWHs/shelters to increase the utilization of the MHWs to promote institutional deliveries by bringing pregnant women closer to health facilities.

15. **Subcomponent 3.5: Health System Digitalization and Related Innovations**. To complement the integrated outreach model with key digital technology innovations to strengthen the financing and accountability at the first level of care and the monitoring of private sector facilities.

Legal Operational Policies

	Triggered?
Projects on International Waterways OP 7.50	No
Projects in Disputed Areas OP 7.60	No

Summary of Assessment of Environmental and Social Risks and Impacts

Environmental and Social Risk Rating: Substantial

16. The Project will have overall positive environmental and social impacts on community especially women by rehabilitating maternity waiting homes (MWHs), contributing to community/public health safety through treatment and surveillance of disease, and good environmental management practices by increasing efficiency and reducing wastepaper through digitization of health system. However, environmental, and social risks have been assessed and rated substantial.

17. **Environmental and Social risks assessment**. Considering the proposed AF activities, such as the integrated outreach service delivery model, community health services including disease surveillance, commodity security, revitalization of MWHs, and health system digitalization and related innovations, the most significant foreseen social risks are related to: (i) exclusion of vulnerable social groups (poor, disabled, elderly, isolated communities, refugees, and people and communities living far from the health facilities, etc.) from access to the essential health services, (ii) inadequate personal data protection under the health system digitalization and related innovations activities, which involve capacity building for using

electronic health records and implementing the early warning system using machine learning and artificial intelligence to detect service disruption, (iii) poor labor and working conditions due to a failure to abide by national legislation and the ESS2 requirements on working hours, wages, overtime, compensation and/or benefits; and (iv) sexual exploitation and abuse, and sexual harassment (SEA/SH) among project workers, with stakeholders and/or local communities. The activities to revitalize MWHs will involve minor civil works such as renovation and refurbishment of existing MWHs, and no land acquisition or involuntary resettlement impacts are expected. Key Environment risks include (i) construction related risks including EHS and OHS (dust, noise, construction waste, working at height, being hit by objects etc.) emanating from refurbishment of maternity waiting homes; (ii) road traffic incidents due to operation of tricycles supporting community health services, vans and motorcycles for health center monitoring ; (iii) exposure to hazardous, medical and e-wastes emanating from immunization, and health care operations and digitization and solar powered equipment, if improperly managed; and (iv) OHS risks during operation of maternity waiting home and management of child illnesses including traps, falls and general wastes management.

18. **Environmental and Social risk management.** To address these environmental and social risks and impacts, the Borrower has updated and re-disclosed through MOHCC and Cordaid websites, the safeguard instruments for the parent project (ESCP and SEP) prior to the Decision Meeting date to reflect the AF activities and associated risks, impacts, and mitigation measures. However, since the project is using the condensed procedures as defined in paragraph 12, section III of the Bank Policy (BP) for Investment Project Financing (IPF), the ESMF (which includes the LMP) will be updated and disclosed within 60 days of project's effectiveness date. Due to the scope and type of waste generation in the parent project, the client prepared an Infection Control and Waste Management Plan, which will be reviewed for its adequacy in managing AF-generated wastes and updated accordingly. The current parent project provisions for grievance management, including measures for addressing SEA/SH, remain relevant and adequate for this AF.

E. Implementation

Institutional and Implementation Arrangements

19. **The Catholic Organization for Relief and Development Aid (Cordaid) remains the Project Implementing Entity (PIE) for the AF.** Day to day management of the project is carried out by the PIE under the close supervision of the Policy and Planning Department within the MoHCC. Cordaid is currently the PIE for the ZCERP and the ongoing World Bank-GFF-financed HSDSP AF V, which has a COVID19 Response Component. The PIE will be reinforced to effectively support the ZCERP and the proposed AF, namely, the Zimbabwe COVID-19 Emergency Response and Essential Health Services Project (ZCEREHSP).

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APPROVAL

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