



Combined Project Information Documents / Integrated Safeguards Datasheet (PID/ISDS)

Appraisal Stage | Date Prepared/Updated: 21-Nov-2018 | Report No: PIDISDSA25753

**BASIC INFORMATION****A. Basic Project Data**

Country Zimbabwe	Project ID P168734	Project Name Zimbabwe Health Sector Development Support Project IV - AF	Parent Project ID (if any) P125229
Parent Project Name Health Sector Development Support Project	Region AFRICA	Estimated Appraisal Date 12-Nov-2018	Estimated Board Date 14-Dec-2018
Practice Area (Lead) Health, Nutrition & Population	Financing Instrument Investment Project Financing	Borrower(s) Ministry of Finance, Department of International Cooperation, Government of Zimbabwe	Implementing Agency Stichting Cordaid

Proposed Development Objective(s) Parent

The Project Development Objective (PDO) is to increase coverage of key maternal and child health interventions in targeted rural districts consistent with the Recipient's ongoing health initiatives.

Proposed Development Objective(s) Additional Financing

The Project Development Objective is to increase coverage and quality of key MCH services in targeted rural and urban districts and strengthen institutional capacity for results-based financing contract management, consistent with the Recipients' ongoing health initiatives.

Components

Delivery of Packages of Key Maternal, Child and Other Related Health Services
 Management and capacity building in Results-Based Financing
 Monitoring, Documentation, and Verification of Results under Performance-based Contracts

PROJECT FINANCING DATA (US\$, Millions)**SUMMARY**

Total Project Cost	10.20
Total Financing	10.20
of which IBRD/IDA	0.00
Financing Gap	0.00



DETAILS

Non-World Bank Group Financing

Counterpart Funding	7.20
Borrower	7.20
Trust Funds	3.00
Global Financing Facility	3.00

Environmental Assessment Category

B-Partial Assessment

Decision

The review did authorize the team to appraise and negotiate

Other Decision (as needed)

B. Introduction and Context

Country Context

1. **Zimbabwe is a landlocked, middle-income country with a Gross Domestic Product (GDP) of US\$18.1 billion, per capita GDP of US\$1231 and a population of 14.6 million (2017 estimates).** The country borders South Africa, Mozambique, Botswana and Zambia. Between 1999 and 2008, Zimbabwe’s economy contracted by an estimated 45 percent and experienced hyperinflation due to disruptions caused by the land reform program and flawed macroeconomic policies. The country’s economy rebounded in 2009 as GDP grew by 40 percent between 2009 and 2012 (an annual average growth rate of 10 percent). GDP growth slowed down between 2013 and 2015 (averaging 3 percent per year) and was estimated to be 1 percent in 2016. The country remains vulnerable to shocks and adverse weather conditions. The 2013 poverty report¹ covering the period 2011-2012 revealed that 72.3 percent of Zimbabweans are poor; a larger share of rural dwellers (84.3 percent) are deemed poor than urban dwellers. The social sector (especially health and education) are constrained by declining public financing, the introduction of informal fees, and an acute shortage of relevant personnel and logistics.

2. **Zimbabwe’s constitution changed in 2013 and after almost four decades under the same leadership, a new Administration assumed office in 2018.** Robert Mugabe resigned as president in November 2017 and Emmerson Mnangagwa was inaugurated as interim President. Zimbabwe held national elections on July 30, 2018. In August 2018 the Constitutional Court confirmed Emmerson Mnangagwa as the winner of the Presidential elections. The new Administration of cabinet ministers, deputies and provincial ministers were sworn into office in September 2018.

¹ Zimbabwe National Statistics Agency (ZimStat)



3. **The new Administration aims to move Zimbabwe toward an Upper Middle-Income Economy by 2030.** The GOZ presented the “New Dispensation Core Values” that aim to move Zimbabwe *Towards an Upper-Middle Income Economy* (TUMIE) by 2030. In line with this vision, it prepared the Transitional Stabilization Program covering October 2018 to December 2020. The Vision 2030 goals will be realized through five strategic clusters: (a) Governance, (b) Macro-economic Stability and Re-engagement; (c) Inclusive Growth; (d) Infrastructure and Utilities; and (e) Social Development which includes investments to improve coverage and quality in health service delivery.

Sectoral and Institutional Context

4. **Despite improvements in key health outcomes post 2009, Zimbabwe’s health sector did not meet its Millennium Development Goals (MDGs) and current progress falls short of the Sustainable Development Goals (SDGs) milestones.** Zimbabwe’s human capital index² is 0.4, which is on par with the Southern African Development Community (SADC) average.³ Life expectancy at birth reached 61 in 2016. Maternal and infant mortality has decreased, as has HIV and tuberculosis (TB) prevalence. However, Zimbabwe remains a high disease burden country and its maternal and child health (MCH) outcomes are among the SADC region’s worst. Sixty five percent of annual deaths are attributed to communicable, maternal, perinatal and nutritional illness, although the share of deaths attributed to noncommunicable diseases has been increasing.⁴ The poor and rural populations shoulder a disproportionate burden of disease and health risks.

5. **Cycles of fragility and macroeconomic challenges coupled with health sector spending inefficiencies shifted the burden of financing health care to households, affecting service utilization.** Zimbabwe’s total health spending per capita compares favorably with the Sub-Saharan Average. However, due to limited fiscal space/ public financing in health and inefficiencies in the sector, households account for the largest share of health sector financing. User fees in health facilities present the largest barrier to service utilization. In 2012, the reason for not seeking treatment when ill was largely financial for the poor, especially for the extremely poor, with over 40 percent of this group indicating unaffordability as the major reason.

6. **Despite health sector improvements particularly in terms of coverage, health care quality remains a critical issue.** Zimbabwe is performing well in terms of coverage of basic maternal, reproductive and child health services compared to the Sub-Saharan Africa average. Nonetheless, the bottleneck analysis conducted for the 2016-2020 National Health Strategy noted that despite high service coverage for most basic health services, quality of care at all levels remains sub-optimal. The analysis also mentioned weak program integration, resulting in missed opportunities to achieve greater impact with the available resources, as well as the lack of continuum of care along the life cycle (newborns, adolescents) and across service delivery levels (community level, tertiary level). The challenging overall

² The index measures the amount of human capital that a child born today can expect to attain by age 18, given the risks of poor health and poor education that prevail in the country where s/he lives.

³ SADC is a regional organization comprised of 14 member countries.

⁴ World Health Organization



macroeconomic context together with inefficiencies in spending also contributes to shortages of drugs, equipment, and qualified health personnel.

7. **Based on the above context, the World Bank has been supporting the GOZ to strengthen its health sector policy and to implement innovative approaches to address priorities through the Health Sector Development Support Project (HSDSP).** The HSDSP supports the GOZ to increase coverage and quality of maternal and child health services. The US\$50 million HSDSP is made up of an original US\$15 million grant approved in September 2011, and three consecutive Additional Financing (AF) grants: a US\$20 million grant approved in July 2013, a US\$10 million grant approved in December 2015; and a US\$5 million grant approved in July 2017. The Health Results Innovation Trust Fund (HRITF) financed the project from inception through the second AF. The project is currently being financed by the HRITF-Global Financing Facility (GFF). The GOZ has also increased its counterpart contribution, starting with US\$1 million for the first AF to US\$2 million for the second AF to US\$5 million for the third AF. The third AF became effective on October 24, 2017. It provides support to the GOZ in delivering high-impact MCH services in targeted rural and urban districts covering an estimated population of 4.1 million people and aims to remove financial barriers to healthcare access on the demand side and strengthen service delivery using RBF. It is also piloting a Continuous Quality Improvement (CQI) Program that has been rolled out to five districts.

8. **In March 2018, the GOZ requested the World Bank for a fourth additional financing to maximize HSDSP development effectiveness by supporting RBF implementation and institutionalization, and the urban voucher scheme.** While the Ministry of Finance and Economic Development (MOFED) had recently allocated US\$7.2 million to the health sector for performance-based payments (subsidies) in the 18 districts that were previously financed by the World Bank project, a financing gap of US\$3.0 million remains. This gap needs to be filled to allow the MOHCC to advance RBF institutionalization, and for Harare and Bulawayo to continue implementing the innovative urban vouchers scheme for subsidized maternity care that the current project is supporting

C. Proposed Development Objective(s)

Original PDO

The Project Development Objective (PDO) is to increase coverage of key maternal and child health interventions in targeted rural districts consistent with the Recipient's ongoing health initiatives.

Current PDO

The proposed PDO is to increase coverage and quality of key MCH services in targeted rural and urban districts and strengthen institutional capacity for RBF contract management, consistent with the Recipients' ongoing health initiatives.

Key Results

- i. Percentage of pregnant women who receive their first antenatal care during their visit to a health provider in participating rural districts
- ii. Percentage of births attended by skilled health personnel in a health institution in participating rural districts
- iii. Percentage of women 15-49 years who receive one of the modern family planning methods, during their first and repeat visits in participating rural districts



- iv. Percentage of children under 5 with diarrhea receiving ORT and Zinc in participating districts
- v. Percentage of partographs correctly filled in participating districts
- vi. Percentage of children under 5 years with Pneumonia correctly managed in the participating districts
- vii. Average quality scores by health facilities in participating rural and urban districts
- viii. Percentage of health facilities managed under RBF contracts by the MOHCC Program Coordination Unit in participating rural districts

D. Project Description

9. **Given Zimbabwe's fragile state context, the HSDS Project has proven to be an effective mechanism for reaching poor populations with a package of priority services with a focus on MCH.** The project enables financing to flow directly to front-line service providers while increasing accountability for performance and for financial resources by health providers in rural areas and low-income urban and peri-urban areas. In addition, the project directly strengthens health system planning and management capacity at decentralized levels. The HSDSP has thus made key contributions to the wider Zimbabwe health system. These contributions are referenced in the Budget Strategy Papers and Budget Statements of the Ministry of Finance and Economic Development (MOFED) and include: **(a)** Increased accountability for results and quality, particularly at health facilities and within their catchment area communities; **(b)** improved accuracy and timely reporting of health service delivery data by health facilities due to RBF penalties and rewards; **(c)** Increased health facility supervision by District Health Executives (DHEs) and Provincial Health Executives (PHEs), which the quarterly RBF grants enabled; **(d)** Strengthened planning and utilization of resources at the health facility level through support provided by RBF for planning and prioritization of funding received; and **(e)** Enhanced community participation through health center committees (HCCs).

10. **The impact evaluation of the parent project also demonstrated significant effects of the RBF mechanism on improving priority health outcomes.** For example, the RBF intervention package increased the rate of deliveries attended by a skilled provider by 15 percentage points and of institutional deliveries by 13 percentage points compared with control districts.

11. **The proposed AF aims to bridge the US\$3.0 million financing gap need to further institutionalize RBF and will continue to support the three original components of the parent project.** These three components are: Component 1: Delivery of Packages of Key Maternal, Child and Other Related Health Services; Component 2: Management and Capacity Building in RBF; and Component 3: Monitoring and Verification of Results. Specifically, the proposed AF will support the following activities listed below, including additional quality improvement innovation and institutional strengthening activities:

- (i) System improvements, including TA to support RBF institutionalization related to policy, procurement, public finance management, information systems, monitoring and evaluation, and the RBF quality component
- (ii) Consultant staffing costs to support the MOHCC, while steps are taken to create regular staff positions within the Government structure
- (iii) The urban vouchers program and the pay-for-quality mechanism that supports ultra-poor households in urban areas
- (iv) Operational costs



12. **To maximize project development effectiveness, this AF proposes to restructure the Project by introducing the following changes:** (i) PDO to better reflect the types of interventions being supported; (ii) Results framework to (a) be in line with the PDO's expanded focus on quality and institutional strengthening in RBF contract management, (b) recategorize certain indicators to align them with the project's results chain, (c) rephrase some indicators to be more specific; and (c) adjust targets based on the proposed additional year of implementation; (iii) Closing date. To allow for implementation of the above activities, the AF proposes to extend the project closing date from December 31, 2018 to December 31, 2019; and (iv) certain institutional arrangements related to PIE staffing and disbursement to reflect the Government's move toward RBF institutionalization in the health sector and the increased focus of AF IV support on TA.

E. Implementation

Institutional and Implementation Arrangements

13. **As in the original project and the three subsequent additional financing operations, CORDAID will continue to serve as the Project Implementing Entity (PIE) and fund-holder for World Bank funds.** However, the MOHCC Program Coordinating Unit (PCU) will now assume the role of national purchaser for RBF services in the 18 rural districts supported by the HSDSP. The latter is in line with the GOZ's RBF institutionalization plan, which includes its commitment to fully finance RBF subsidies for the 18 rural districts that will be supported by the fourth additional financing (AF IV). The AF will have a more streamlined PIE staffing structure that reflects both increased government capacity in RBF and the project's increasing technical focus. The PIE staffing structure will continue to facilitate capacity building and skills transfer from Cordaid to the MOHCC to further strengthen the MOHCC's capacity to execute key RBF functions such as purchasing and fund holding. It is envisioned that the MOHCC-PCU will progressively take over the purchasing function in the remaining 44 rural districts which are currently being supported by the Health Development Fund (HDF) with Crown Agents as the purchasing agent.

14. **The MOFED and the MOHCC's Policy, Planning and Monitoring and Evaluation Directorate, Finance and Administration Directorate and the Family Health Division will continue to play a lead role in project technical direction and management oversight.** The Ministry of Public Service, Labor and Social Welfare together with the local governments from the cities participating in the urban voucher program (Harare and Bulawayo) will coordinate client engagement, community monitoring, and report to the PIE and the MOFED on voucher utilization by targeted urban households. The core team of GOZ staff seconded to lead RBF will continue to work closely with CORDAID in operational, management and verification aspects of the project. To promote sustainability and in line with its mandate, the Health Professionals Association will assume the counter-verification role, taking over the University of Zimbabwe's role.

Components:

15. **As per the GOZ's request and in line with discussions with the Government, lessons learnt, and findings of recent process assessments, AF IV will continue to support the three current project components.** The activities reflect the increased focus on TA. While one of the AF's major objectives would be to strengthen institutional capacity for the Government to manage RBF contracts, support will continue



to include measures to improve coverage and quality, building on lessons learnt from implementation and assessments.

Component 1: Delivery of Packages of Key Maternal, Child and Other Related Health Services

Sub-Component 1.a. Supply-side RBF in 18 rural districts

16. This sub-component currently supports: **(i)** the delivery of basic health service packages in 18 targeted rural districts, with a focus on MCH through results-based contracts with health service providers;⁵ and **(ii)** supervision of such health services through results-based contracts with district, provincial and national health management teams. The proposed AF will continue to finance such activities. The major change regarding sub-component financing is that the GOZ will fully assume financing of performance-based payments in the 18 rural districts.

Sub-Component 1.b. Demand- and supply-side RBF for low-income urban families

17. This sub-component targeting low-income urban districts aims to: **(i)** protect the urban poor from the financial burden of seeking primary care health services, specifically focusing on maternal and neonatal care; **(ii)** improve quality of services in urban public facilities; and **(iii)** improve health behaviors of poor urban populations. The proposed AF will continue to support such activities.

18. Based on the preliminary results of the Urban Voucher (UV) program process assessment and the assessment undertaken by the Population Council in 2015, the AF will contribute to: **(i)** Fine-tuning selection criteria to better target poor households; **(ii)** Enhancing the mechanism of active identification of potential clients and client follow-up; **(iii)** Reviewing the package of services being offered; **(iv)** Exploring options for scaling up the quality focused supply-side urban RBF to more facilities and areas in the two cities; **(v)** Improving referral mechanisms; and **(vi)** Strengthening the Beneficiary Voucher Registration (BVR) System.

19. The AF IV will be complemented by the Policy and Human Resources Development Grant in providing TA to explore options for expanding and financing the UV program.

Component 2: Management and Capacity Building in RBF

20. This component will continue to support interventions to strengthen the capacity of health service providers and health supervisors to provide and oversee health services. It will finance: **(i)** basic medical equipment and other related goods; and **(ii)** training and technical assistance to the MOHCC, the MOFED and Ministry of Public Service, Labor and Social Welfare (MOPSLSW) to improve capacity to manage RBF-related services provided under Component 1 (e.g. financing and financial management, monitoring, reporting and evaluation and financial management).

⁵ The scope and focus of the RBF national program was widened in May 2017 to reflect integration of reproductive, maternal and child health services with other diseases ranking high in the country's burden of disease: HIV/AIDS, Tuberculosis, Malaria and Non-Communicable Diseases (NCDs)



21. Building on the progress so far, lessons learnt from project implementation, the Rwanda Study visit conducted in April 2018, and process assessments, the AF will further support: **(i)** RBF institutionalization including governance and strategic RBF management capacity at national and sub-national levels; **(ii)** Strengthening CQI innovations to improve training (for example, shifting to a more hands-on, practical approach), verification and supervision; and **(iii)** Providing TA to enhance the performance of the Quality Assurance/ Quality Improvement Directorate (QAD) of the MOHCC.

Component 3: Monitoring and Verification of Results

22. Broadly, Component 3 supports project supervision, monitoring, evaluation and external verification. The AF will continue to finance such activities. It will particularly support strengthening data management systems at national, provincial, and district levels. Process evaluations will continue to feed into the implementation of supply-side and demand-side RBF mechanisms. For example, aside from the CQI and urban voucher process evaluations, the AF will contribute to finalize the process evaluation to examine cost-effective options for verifying results under RBF schemes. This builds upon the pilot risk-based verification approach initiated under the second AF and continued in the third AF. Further process evaluations will be considered depending on future needs.

F. Project location and Salient physical characteristics relevant to the safeguard analysis (if known)

Project implementation will continue to take place in 18 districts in 8 provinces in Zimbabwe with a focus on rural health facilities as well as the two main cities, Harare and Bulawayo.

G. Environmental and Social Safeguards Specialists on the Team

M. Yaa Pokua Afriyie Opong, Social Specialist
Majbritt Fiil-Flynn, Social Specialist
Mwansa Lukwesa, Environmental Specialist

SAFEGUARD POLICIES THAT MIGHT APPLY

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	Activities in AF IV are similar to those in the Parent Project and AFs I to III. As was done in AFs I to III, no major civil works will be undertaken in AF IV, only upgrading/minor renovations (such as painting, plastering of walls, replacement of ceilings, etc.). Upgrading/minor works will follow national



		requirements. These are not expected to have any environmental impacts on the ground. However, improvements in both health services and access will be continued which will increase the quantity of health services and require management of increased amounts of infectious medical waste.
Performance Standards for Private Sector Activities OP/BP 4.03	No	The policy is not triggered because the project works with public institutions including health facilities.
Natural Habitats OP/BP 4.04	No	The policy is not triggered as the project will be restricted to already existing health facilities and no ecologically sensitive habitats will be disturbed.
Forests OP/BP 4.36	No	The policy is not triggered as the project will involve the loss of trees.
Pest Management OP 4.09	No	The policy is not triggered as the project will not finance the use of pesticides.
Physical Cultural Resources OP/BP 4.11	No	The policy is not triggered as the project will not involve any earth works that will result in chance finds. All minor civil and renovation works will be restricted to already existing structures.
Indigenous Peoples OP/BP 4.10	No	The policy is not triggered as there are no indigenous people in the project locations as defined by Bank policy.
Involuntary Resettlement OP/BP 4.12	No	There are no activities under the project that would require land acquisition or adversely impact livelihoods. There is no new construction under the Project but financing may support minor works in already existing rural health centers.
Safety of Dams OP/BP 4.37	No	The policy is not triggered because the AF will not involve the construction of dams.
Projects on International Waterways OP/BP 7.50	No	The policy is not triggered as the AF will not be implemented on any international waterways.
Projects in Disputed Areas OP/BP 7.60	No	The policy is not triggered as the AF will not be implemented in any disputed area.

KEY SAFEGUARD POLICY ISSUES AND THEIR MANAGEMENT

A. Summary of Key Safeguard Issues

1. Describe any safeguard issues and impacts associated with the proposed project. Identify and describe any potential large scale, significant and/or irreversible impacts:

The investments to be supported by the AF are similar to those financed under the Parent Project and Additional Financings (AFs) I to III; therefore, the AF will maintain the Environmental Category B classification of the Parent Project and three AFs. Implementation of health care waste management has been largely satisfactory.



2. Describe any potential indirect and/or long term impacts due to anticipated future activities in the project area: The sub-projects to be supported under the AF will not generate indirect and/or long-term impacts envisaged in the project areas.

3. Describe any project alternatives (if relevant) considered to help avoid or minimize adverse impacts. The alternative to avoid the environmental impact is a no project alternative, which is not acceptable in view of the high morbidity and mortality rates of women and children in the country.

4. Describe measures taken by the borrower to address safeguard policy issues. Provide an assessment of borrower capacity to plan and implement the measures described.

During the preparation of the Parent Project, the Borrower prepared a Health Care Waste Management Plan (HCWMP). A review of the implementation experience of the HCWMP was conducted in 2016 and a workshop was organized with stakeholders that included the Ministry of Health and Child Care (MOHCC), Environmental Management Agency, provincial and district stakeholders to discuss the recommendations, a number of which are already being implemented through the project. The project design incorporates the safe and responsible handling and disposal of medical waste through several measures. Additionally, the quality verification tool, a supervision checklist that is being administered on a quarterly basis, includes verification of medical waste measures implemented by health facilities. Indicators of medical waste handling were updated as part of the 2016 HCWMP implementation review and are being monitored in every facility on a regular basis. Poor performance on the facility quality tool score impacts the amount of the performance grant a facility will receive so facilities that perform better on waste management practices receive higher grants. This will incentivize health workers to adopt good waste management practices and ensure that staff adhere to the guidelines. The Borrower has experience in supporting Bank funded projects and has an existing health care waste management plan.

5. Identify the key stakeholders and describe the mechanisms for consultation and disclosure on safeguard policies, with an emphasis on potentially affected people.

The Health Care Waste Management Plan (HCWMP) was prepared using a broad-based public consultative approach, involving stakeholder groups in the health sector and NGOs, private sector institutions and local communities at the different administrative levels. The HCWMP report was publicly disclosed in-country in April 2011 through a series of workshops.

The MOHCC is developing a Regulation on Health Care Waste Management - the first of its kind in Zimbabwe. The regulation is undergoing legal review and will then be presented to Parliament for ratification. Once Parliament approves it, the HCWMP will be reviewed.

B. Disclosure Requirements (N.B. The sections below appear only if corresponding safeguard policy is triggered)

Environmental Assessment/Audit/Management Plan/Other

Date of receipt by the Bank 18-Apr-2011	Date of submission for disclosure 26-May-2011	For category A projects, date of distributing the Executive Summary of the EA to the Executive Directors
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"In country" Disclosure



If the project triggers the Pest Management and/or Physical Cultural Resources policies, the respective issues are to be addressed and disclosed as part of the Environmental Assessment/Audit/or EMP.

If in-country disclosure of any of the above documents is not expected, please explain why:

C. Compliance Monitoring Indicators at the Corporate Level (to be filled in when the ISDS is finalized by the project decision meeting) (N.B. The sections below appear only if corresponding safeguard policy is triggered)

OP/BP/GP 4.01 - Environment Assessment

Does the project require a stand-alone EA (including EMP) report?

No

The World Bank Policy on Disclosure of Information

Have relevant safeguard policies documents been sent to the World Bank for disclosure?

Yes

Have relevant documents been disclosed in-country in a public place in a form and language that are understandable and accessible to project-affected groups and local NGOs?

Yes

All Safeguard Policies

Have satisfactory calendar, budget and clear institutional responsibilities been prepared for the implementation of measures related to safeguard policies?

Yes

Have costs related to safeguard policy measures been included in the project cost?

Yes

Does the Monitoring and Evaluation system of the project include the monitoring of safeguard impacts and measures related to safeguard policies?

Yes

Have satisfactory implementation arrangements been agreed with the borrower and the same been adequately reflected in the project legal documents?

Yes



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APPROVAL

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