



Project Information Document (PID)

Appraisal Stage | Date Prepared/Updated: 08-May-2020 | Report No: PIDISDSA29536



BASIC INFORMATION

A. Basic Project Data

Country Eswatini	Project ID P168564	Project Name Health System Strengthening for Human Capital Development in Eswatini	Parent Project ID (if any)
Region AFRICA	Estimated Appraisal Date 30-Apr-2020	Estimated Board Date 22-Jun-2020	Practice Area (Lead) Health, Nutrition & Population
Financing Instrument Investment Project Financing	Borrower(s) Kingdom of Eswatini	Implementing Agency Ministry of Health	

Proposed Development Objective(s)

The project development objective is to improve the coverage and quality of key reproductive, maternal, neonatal, child and adolescent health (RMNCAH), nutrition and NCD services (hypertension and diabetes) in Eswatini.

Components

- Component 1: Improve health service delivery to increase the coverage and quality of health services to build human capital
- Component 2. Increase community demand for RMNCAH, nutrition and NCD services
- Component 3. Strengthen the MOH’s stewardship capacity to manage essential health and nutrition services and project activities
- Component 4: Contingent Emergency Response Component

PROJECT FINANCING DATA (US\$, Millions)

SUMMARY

Total Project Cost	20.00
Total Financing	20.00
of which IBRD/IDA	20.00
Financing Gap	0.00

DETAILS



World Bank Group Financing

International Bank for Reconstruction and Development (IBRD)	20.00
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Environmental and Social Risk Classification

Moderate

Decision

The review did authorize the team to appraise and negotiate

B. Introduction and Context

Country Context

1. **The Kingdom of Eswatini is a mountainous, landlocked, small open economy in Southern Africa, with four administrative regions.** The population is 1.1 million and 78 percent live in rural areas. As a ‘monarchical democracy’, absolute power rests with the monarch. Traditional and parliamentary systems run concurrently. The Kingdom has close economic links to South Africa on which it depends for about 85 percent of its imports and 60 percent of its exports. Eswatini is a member of the Common Monetary Area with Lesotho, Namibia, and South Africa, under which the Eswatini lilangeni (SZL) is pegged at par to the South African rand.

2. **Although it is classified as a lower-middle-income country (gross national income per capita US\$2,960), high poverty rates and income inequality challenge Eswatini’s economic and human development potential.** While the national poverty rate¹ has fallen in recent years (from 63 percent in 2010 to 59 percent in 2017), it remains high, particularly in rural areas (70 percent) and in two regions (Lubombo - 72 percent and Shiselweni - 67 percent). Eswatini’s hunger levels are ‘serious’;² almost two-thirds of the population are food insecure³ with detrimental impact on pregnant women and children.

3. **Macroeconomic performance has been hampered by severe droughts due to climate change and growing fiscal challenges emanating from rapid growth in the public wage bill combined with volatile Southern African Customs Union transfers.** Gross domestic product (GDP) growth rate was 2.4 percent in 2018. The 2019 contraction caused a high fiscal deficit and cash flow challenges. In 2019, the International Monetary Fund urged Eswatini to undertake expenditure rationalization.⁴ With the Government’s focus on reducing the structural and fiscal imbalances, the 2020–21 budget depicts a positive outlook with a growth recovery up to 2.9 percent in 2020.⁵

¹ The proportion of Emaswati living below the upper bound poverty line of SZL 975.3 per adult equivalent per month (in January 2017 prices).

² 2018 Global Hunger Index.

³ EHIES 2017; World Bank 2020.

⁴ IMF. 2019. *Eswatini: Exploring Options for Expenditure Rationalization*. Technical Report.

⁵ Kingdom of Eswatini Budget 2020/21 At a Glance, Budget and Economic Affairs Department, Ministry of Finance.



4. **As a result of the outbreak of the 2019 novel coronavirus, growth projections have been muted to below 1 percent for 2020.** As the spread of the virus severely affects trade and supply chains and depresses consumption and demand in affected countries, economic growth has been revised down substantially in China, the United States, and the G-20 economies, including South Africa. This has resulted in a downward revision of Eswatini's forecasts, given its close ties with the South African economy. While there is not enough information currently about the risk of coronavirus disease 2019 (COVID-19) in human immunodeficiency virus (HIV) populations, evidence from other viral respiratory infections suggests that COVID-19 may be very dangerous for populations with a large proportion of people having suppressed immunity such as from HIV and tuberculosis as well as those with high levels of poverty and malnutrition.

5. **On March 17, 2020, Eswatini declared a state of emergency.** The primary crisis is one of health. The fundamental concern is to contain the disease and delay the spread of infection. The Government of Eswatini (GOE) recognizes that the cost of not acting could be detrimental and this includes actions beyond the emergency response. Investments today in strengthening the health system are urgent and critical to protect Eswatini's economic and human capital potentials.

6. **Eswatini's National Development Strategy, Vision 2022,** defines its aspiration to be in the "top 10% of the medium human development group of countries" and commitment to address issues of poverty and access to quality health care, gender equity, and social integration, emphasizing technology use and innovation to help reach its vision.

7. **Recognizing the importance of human capital as a central contributor to sustainable economic growth and poverty reduction, in March 2019, Eswatini joined the group of early adopters of the Human Capital Project.** Despite its lower-middle-income status, Eswatini's Human Capital Index (HCI)—a composite measure of under-five children survival rate, educational attainment, and adult survival rate and stunting—is low, on par with the Sub-Saharan average and lower-income countries. An HCI score of 0.41⁶ indicates that a child born today in Eswatini will only be 41 percent as productive when s/he grows up as s/he could be if s/he benefited from complete education and full health. Investing in human capital would increase the GDP per worker. To meet Eswatini's vision for human development, about 15 percentage point increase is required from its current HCI score, calling for improvements in health, nutrition, and education services and cross-sectoral synergies.

8. **Human capital is also a priority for the World Bank.** The proposed project, in line with the GOE's strategic priorities, focuses on strengthening the health system and community platforms to help address critical human capital challenges, including stunting, child mortality, and adult mortality. The project also builds on prior support and lessons from Eswatini engagement and complements efforts by the Government and the World Bank in other sectors to support the human capital agenda, including education and water supply and sanitation.

Sectoral and Institutional Context

9. **Eswatini's HIV epidemic, persistently high maternal and child mortality, increasing noncommunicable diseases (NCDs), and malnutrition affect its human capital formation.** Eswatini has the highest HIV prevalence in the world, with more than a quarter (27 percent) of its reproductive-age

⁶ The achievements on the HCI's health dimensions are probability of survival to age five = 95 percent; adult survival rate = 59 percent; not stunted rate = 74 percent.



population living with HIV. While the national HIV response has achieved significant success, particularly in its rapid scale-up of antiretroviral treatment and evidenced by a 44 percent reduction in HIV incidence from 2011 to 2016, challenges remain. HIV incidence is the highest in the world and HIV remains the leading cause of death in the country. Furthermore, high levels of maternal and child mortality and stunting, coupled with a surge in NCDs, further drive Eswatini's performance on the HCI, particularly in relation to child survival and stunting and adult survival.

10. **The number of maternal and neonatal deaths is high due to failure to provide high-quality, responsive care to pregnant women and their babies in health facilities.** Despite increased access to antenatal care (ANC, 76 percent attend at least four visits) and to women delivering in health facilities (88 percent), Eswatini's maternal mortality ratio remains very high (437/100,000).⁷ Most maternal deaths are linked to poor quality of care in facilities including lack of or poor monitoring, substandard management, and delayed intervention and referral.⁸ Quality of ANC is also a challenge.⁹ Almost all maternal deaths are deemed avoidable, with most deaths associated with obstetric hemorrhage (15 percent of deaths), hypertensive diseases of pregnancy (8 percent), and pregnancy-related sepsis (8 percent). While there has been better progress with neonatal mortality (17.2 deaths per 1,000 births), neonatal deaths still account for a third of total under-five deaths. More than 600 perinatal deaths were registered in 2018, of which 27 percent were recorded as fresh still born, 38 percent as macerated still born, and 35 percent as an early neonatal death, pointing to challenges across the continuum of care, from antenatal to delivery and postnatal care. Beyond the neonatal period, mortality among children under five years is driven by diarrhea (20 percent of under-five deaths), lower respiratory infections (17 percent), HIV (11 percent), and protein-energy malnutrition (5 percent).¹⁰

11. **Adolescent girls and their babies are particularly vulnerable to poor outcomes.** High teenage pregnancy in Eswatini is a significant barrier to human capital accumulation. While the adolescent fertility rate has declined in recent decades, at 77 births per 1,000 girls (2017), it still remains very high; it is more than double the rate observed in South Asia for example and up to 30 percent of all pregnancies in Eswatini are among adolescents. In the large-scale Sitakhela Likusasa Impact Evaluation,¹¹ almost half (44 percent) of adolescent girls and young women (AGYW) reported ever being pregnant. The study highlighted the importance of education on health and fertility and the need to strengthen family planning for AGYW; more than half (56 percent) of participants reported having never spoken to anybody about contraception and one in five was not using any contraception despite being sexually active. In addition to its negative impact on girls' education (two-thirds of girls who drop out of secondary education in Eswatini do so as a result of pregnancy) and the consequent risk of HIV, teenage pregnancy significantly contributes to high anemia and malnutrition in adolescents, maternal and child morbidity and mortality, and vicious intergenerational cycles of poor health and poverty. Adolescent girls who become pregnant are more likely to be socially isolated and suffer from depression. They are less likely to attend ANC (67 percent attend four visits versus 84 percent in women 35+ years). Their infants are more likely to be born preterm, have a low birth weight, become stunted and die as an infant compared to infants born to older

⁷ World Bank Open Data. 2018. Accessed February 29, 2020.

⁸ ASA P163653; Confidential enquiry on maternal deaths (2014–2016).

⁹ Healthy Mothers, Healthy Babies: A Study to Assess Quality of Care in Maternity and Neonatal Services, supported by ASA P163653.

¹⁰ Institute for Health Metrics & Evaluation. 2017. "Global Burden of Disease 2017." University of Washington. <https://vizhub.healthdata.org/gbd-compare/>

¹¹ Conducted as part of the World Bank ASA HIV Incentives Evaluations in Swaziland and South Africa (P151327).



mothers. Infants born to adolescent mothers are also more likely to grow up in an unsupportive home environment; have poor cognitive development; drop out of school; be unemployed or underemployed; and, if female, become pregnant in their adolescence, thereby cementing the perpetual intergenerational poverty cycle and contributing to the intergenerational cycle of malnutrition. Indeed, a strong negative correlation exists between fertility and human capital (-0.82) and GDP per capita (-0.78).

12. A triple burden of malnutrition (undernutrition, overnutrition, and micronutrient deficiency) adversely affects Eswatini's human capital.

- **A quarter of children under five years in Eswatini are stunted and 2 percent are wasted (2014),¹²** which is linked to poor breastfeeding practices and quality of complementary foods (low dietary diversity) especially among infants.¹³ Stunting is more prevalent in rural (27 percent) compared to urban areas (19 percent) and among children living in the poorest (30 percent) compared to the richest households (9 percent).
- **The prevalence of overweight/obesity is high among women and children.** About 9 percent of children under five years are overweight or obese, with prevalence being higher in urban compared to rural areas (12 percent versus 8 percent) and among children living in the richest compared to the poorest households (18 percent versus 6 percent). Additionally, more than half of the women of reproductive age (51 percent) are either overweight or obese (18 percent among men).
- **The prevalence of micronutrient deficiency is also high among women and children.** The prevalence of anemia among women, pregnant women, and children under five years is 27 percent, 30 percent, and 42 percent, respectively.¹⁴
- **Malnutrition has a long-term negative impact on health, knowledge, skills, and productivity.** Malnutrition in the first years of life affects childhood survival, early childhood development, learning abilities, and educational outcomes in school, with long-term negative consequences for work productivity and economic development. In 2009, the estimated economic impact of child stunting—which was only marginally higher at the time (31 percent) than current estimates—was SZL 783 million (3.1 percent of GDP). Stunting puts children at higher risk of NCDs in later life. Obesity also causes NCDs and leads to increased health care costs, reduced work productivity, increased disability, and premature deaths.¹⁵ Among women, it also contributes to premature deliveries, low birth weight, and other poor birth outcomes.

13. The rapid increase in NCD prevalence has resulted in a high number of avoidable morbidities and premature deaths, negatively affecting human capital.¹⁶ NCDs as a cause of mortality increased from

¹² Central Statistics Office. 2016. "Swaziland Multiple Indicator Cluster Survey 2014."

¹³ Multiple Indicator Cluster Survey 2014.

¹⁴ Eswatini 2018 Nutrition Country Profile. GlobalNutritionreport.org.

World Bank Open Data. 2016. Accessed March 1, 2020.

¹⁵ World Bank 2020. *Obesity: Health and Economic Consequences of an Impending Global Challenge*.

¹⁶ Enhancing Human Capital and Boosting Productivity by Tackling Non-communicable Diseases: A Joint Agenda for Countries and Partners. The World Bank Group Human Capital Project, September 2019.



23 percent in 2007 to 40 percent in 2017, with most NCD-related deaths linked to cardiovascular diseases, diabetes, and kidney diseases. Adult prevalence of hypertension and type-2 diabetes (key risk factors for cardiovascular diseases) is 25 percent and 14 percent, respectively, with significant drop-offs across the cascade of care, highlighting systemwide deficits, including failures in primary care and inadequate coordination and continuity of care.¹⁷ Currently, the majority of NCD service delivery, including uncomplicated cases, is provided by physician-led teams at tertiary-level facilities. Screening is done on an ad hoc basis. Furthermore, there are gender disparities in NCDs; while the prevalence of hypertension and diabetes is higher among women, men are less likely to seek care and achieve disease control.

14. The above health challenges are due to shortcomings in Eswatini’s health system foundations that lead to poor quality care, as follows:

Population health needs, expectations, and demand

- Eswatini’s health system is not aligned with population health needs.
- Client experience and satisfaction with health services is low.
- Poor utilization of health services is linked to sociocultural beliefs and practices and lack of knowledge and awareness.

Stewardship, governance, and financing

- Eswatini’s health system performance is hampered by outdated legislation and weak regulation and accountability and management structures.
- While Eswatini’s per capita spending on health (US\$233)¹⁸ increased between 2017 and 2019, macroeconomic challenges have led to reduced fiscal space for health.

Health system platforms and organization of care

- The success in fighting HIV fragmented Eswatini’s health system, resulting in service delivery silos with significantly different capacity, transparency, and performance.
- Eswatini relies on several platforms for health service delivery, organized in five levels.
- Eswatini’s community-based health services requires strengthening.
- Primary health care facilities have been neglected.
- The effective use of hospitals and quality of care in hospitals also requires attention.

¹⁷ Kruk, et al. 2018. “High-quality Health Systems in the SDGs Era: Time for a Revolution.” *Lancet Glob Health* 6 (11): e1196–e1252.

¹⁸ Per capita health expenditure was estimated at US\$233 in 2016, which is above the income group average of about US\$60. The most recent 2017/18 National Health Accounts (2019 unpublished draft) indicates significant increase in per capita health spending.



Availability of competent and motivated health workers

- Eswatini has a shortage of specialists and an outdated skill mix.
- Competency, performance, and motivation among available health workers is a challenge.

Essential medicines, commodities, and equipment

- Stock-outs of essential medicines and consumables is a challenge in Eswatini.
- The delivery of essential services is hampered by lack of functional equipment due to poor tracking of available equipment and their maintenance and repair needs.

Data and digital health technology

- Eswatini’s electronic medical record, known as the Client Management Information System, is available in less than half of the facilities (48 percent) and does not cover, or inadequately covers, all health conditions.
- Other digital health technology is not used extensively in Eswatini, including for client communication and self-monitoring, clinical case management, and health care provider decision support and referral coordination.

15. **To meet the policy objective of the National Health Sector Strategic Plan (NHSSP II 2019–23)—“build an efficient, equitable, client-centered health system for accelerated attainment of the highest standard of health for all people in Eswatini”—the Ministry of Health (MOH) recognizes the need to invest in health system strengthening to improve the coverage of essential services and the quality of care. The recent coronavirus outbreak has underscored the importance of a responsive and resilient health system. Modernizing the foundations of the health system and applying evidence-based improvements are key to achieving better quality care and, through that, reduced child and adult mortality and stunting for human capital formation.**

16. **The proposed operation will support the MOH and the GOE to (a) progress with the implementation of NHSSP II (2019–23), which promises universal health coverage to all Eswatini; (b) improve service delivery; and (c) advance Eswatini’s human capital agenda.** The project will complement and support significant government investments in these areas.

17. **The proposed project complements the Eswatini COVID-19 Emergency Response Project (P173883) and is designed to deepen and extend its investment impact through focusing on medium-term structural changes and the modernization of the health sector.** While the emergency operation focuses on short-term needs to support capacity in prevention, detection, and response to the threat posed by the COVID-19, this operation offers a medium-term horizon to strengthen the health system’s foundations and its preparedness to respond to the population’s health needs, including through strengthened health facilities that can provide high-quality care to COVID-19 patients and those with chronic diseases that are particularly susceptible to severe coronavirus disease, digital platforms for real-time responsive data tracking and use, and governance and stewardship to efficiently and effectively manage the health response in such a dynamic environment.



C. Proposed Development Objective(s)

Development Objective(s) (From PAD)

18. The Project Development Objective (PDO) is to improve the coverage and quality of key reproductive, maternal, neonatal, child and adolescent health (RMNCAH), nutrition and NCD services (hypertension and diabetes) in Eswatini.

Key Results

19. The PDO-level indicators will be as follows:

- (a) Percentage of patients diagnosed with hypertension and diabetes who are managed at the PHC level (coverage)
- (b) Percentage of children under 5 years of age provided with a basic package of nutrition specific services (coverage)
- (c) Percentage of adolescents served or reached with quality sexual and reproductive health services (coverage)
- (d) Percentage of pregnant women receiving at least 4 ANC visits that meet defined quality standards (quality)
- (e) Percentage of health facilities that meet a minimum standard of quality as measured by a Health Facility Quality Index (quality).¹⁹

D. Project Description

20. To address key sector challenges and support the achievement of the PDO, the proposed project would be financed by an IBRD loan of US\$20 million, using an Investment Project Financing (IPF) instrument, over a five-year period. The project will focus on strengthening the health system and ramping up investments in reproductive, maternal, neonatal, child, and adolescent health (RMNCAH) services as well as nutrition and NCDs (hypertension and diabetes) to address critical human capital challenges, including stunting and child and adult mortality, applying a life course approach. The project includes the following components.

Component 1. Improve health service delivery to increase the coverage and quality of health services to build human capital (US\$14.5 million)

21. This component will improve health service delivery to integrate and scale up quality nutrition and NCD services in primary health care and enhance the quality of RMNCAH services across the continuum of care. Under this component, the project will (a) build the capacity of health care workers to deliver high-quality RMNCAH, nutrition, and NCD services in primary health care and higher-level care for continuity; (b) increase the availability of drugs, commodities, functioning equipment, and client data to

¹⁹ The index will be tailored to level of care to reflect differences in service profile at the primary and hospital levels.



support the delivery of these services through supply chain strengthening and investments in a digital health system; and (c) strengthen the capacity of facilities, programs, and regions to monitor quality of care, provide supportive supervision, and implement a Quality Management Approach (QMA) in facilities to ensure that the above inputs are translated into effective and high-quality service delivery.

Subcomponent 1.1. Build capacity of health care workers to deliver enhanced, high impact RMNCAH, and nutrition and NCD services across the continuum of care (US\$3.0 million)

22. This subcomponent will build the capacity of health care workers to deliver essential and high-quality RMNCAH, nutrition, and NCD services across the continuum of care through trainings, the provision of digital decision support tools ('digital job aids'), and the creation of a Community of Practice for midwives as a platform for sharing best practices and creating new knowledge for continuous professional development.

Subcomponent 1.2. Increase the availability of drugs, commodities, functioning equipment, and client data for high-quality health and nutrition service delivery in facilities (US\$9.5 million)

23. This subcomponent will increase the availability of drugs, commodities, functioning equipment, and client data in facilities critical for RMNCAH, nutrition, and NCD service delivery through strengthening of supply chain management and investing in a digital health system. Procurement of biomedical equipment and supplies for hygiene and sanitation will supplement COVID-19 health care readiness in hospitals and health facilities.

Subcomponent 1.3. Strengthen the capacity of facilities, programs and regions to monitor quality of care, supervise and implement a Quality Management Approach in health facilities (US\$2.0 million)

24. This subcomponent will help ensure that the above inputs translate into the delivery of high-quality services by strengthening the capacity of facilities, programs, and the Regional Health Management Teams²⁰ (RHMTs) to supervise, monitor, and implement a QMA for high-quality RMNCAH, nutrition, and NCD service delivery. The QMA is central for outcome-oriented service organization and management, strengthening the link between health spending and health outcomes. Implementing the program will enable linking quality of care performance to an accreditation process.

Component 2. Increase community demand for RMNCAH, nutrition and NCD services (US\$2.0 million)

25. In addition to supply-side constraints, utilization of RMNCAH, nutrition, and NCD services is also affected by demand-side constraints, including insufficient knowledge of prevention and care and cultural barriers. This component will strengthen the Community Health Volunteer (CHV) program, conduct targeted social behavior change communication (SBCC), and develop client-based digital applications to address social and behavioral bottlenecks and generate demand for quality and service delivery uptake of RMNCAH, nutrition, and NCD services. Specifically, the project will support the following:

- Strengthening of the CHV program to conduct community sensitization and outreach

²⁰ RHMTs are responsible for monitoring and supervising all health facilities and services within their respective region.



- Scale-up of Social Accountability Monitoring of Sexual and Reproductive Health Services
- Targeted SBCC
- Design, development, and scale-up of client-based digital applications to help generate awareness, improve knowledge, and boost uptake of services and adherence to appointments and treatment.

Component 3. Strengthen the MOH’s stewardship capacity to manage essential health and nutrition services and project activities (US\$3.5 million)

26. This component focuses on strengthening the stewardship capacity of the MOH to manage health and nutrition services and project activities. It will also support engaging with the central agencies and other line ministries that are critical for the implementation of the proposed sector strengthening and modernization to build human capital, supported by a Human Capital Liaison. Specifically, the project will provide technical assistance to support the drafting of updated regulations, policies, and strategies including for the draft Health Bill, professional regulatory bodies, National Quality of Care Framework, public-private partnerships, nutrition, health care waste management (HCWM) consisting of the capture or combustion of fugitive methane emissions and health financing. Technical assistance and training for the MOH will also be provided on leadership and management to support modernization and organizational transformation of the MOH; strategic Human Resources for Health (HRH) planning; health planning and financing (including budget planning and monitoring and strategic purchasing); service contract development, negotiation, management, and revision; service delivery organization; climate change and health; and monitoring and evaluation (M&E). This will be complemented with twinning arrangements, particularly relevant during the first 12–18 months of project implementation. The gradual reforms supported under this component are instrumental for the success of the interventions proposed under Components 1 and 2; it situates the micro-level²¹ efforts as part of the broader reforms to sustain their impact.

27. **Project management and M&E.** To ensure effective and efficient project implementation, this component will also support the MOH with fiduciary aspects (financial management [FM] and procurement), project evaluation, and environmental and social (E&S) standards. This will ensure the timely management of procurement of goods and services, financial reporting and audits, consistent and quality data flows for the Results Framework and operational research purposes, and compliance with E&S requirements and the Environmental and Social Commitment Plan. This component will support the functions of the Project Implementation Unit (PIU), which will move toward integrated project management, as well as the relevant functions of the Interministerial Technical Committee and the Interministerial Policy Advisory Group as they relate to the implementation of the project.

Component 4. Contingent Emergency Response Component (US\$0)

28. The project includes a CERC in accordance with the World Bank Policy: Investment Project Financing, paragraphs 12 and 13, for situations of urgent need and assistance. This component will allow for rapid reallocation of project proceeds in the event of a natural or man-made disaster or crisis that has

²¹ Micro-level interventions focus on a narrow set of solutions, such as increasing health system inputs and changing people’s behaviors and routines at the point of care, that is, at the lowest (micro) level of the health system (Kruk et al. 2018).



caused or is likely to imminently cause a major adverse economic and/or social impact during the life of the project. Such events may include a disease outbreak. An assessment using the World Bank’s Climate and Disaster Risk Screening Tool determined that Eswatini is vulnerable to risks because of climate change impacts including droughts, extreme temperature, and inundation due to extreme precipitation and flooding. The CERC will have no funding allocation initially. In the event of an emergency, this component would allow the GOE to request the World Bank to recategorize and reallocate financing from other project components to cover emergency response and recovery costs, if approved by the World Bank.

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

29. **The E&S risk classification of the project is Moderate under the World Bank’s Environmental and Social Framework** based on the type and nature of the project that will support strengthening of health systems for human capital development in Eswatini. Project activities and interventions involving support to improving sector governance and performance (Component 3), health financing, service delivery, supply chain management, infrastructure and equipment maintenance, and health management information systems will require (a) procurement of equipment, including electronic equipment and (b) capacity building and training in the application of analytical computing skills, setting up and use of various computer-based and other management systems, and the use and maintenance of infrastructure and equipment. The environmental impacts associated with these activities will result from the generation and disposal of electronic waste (e-waste) which is considered to have moderate environmental risk and general waste (paper, packaging, redundant non-electronic equipment, food waste, and so on) considered to have low risk.

30. **The Operations Centre will be built on the premises of the existing Central Medical Store site entailing minor construction works.** Support for hospital and health facility operations through the procurement and deployment of biomedical equipment and supplies for hygiene and sanitation is anticipated to result in risks and impacts related to the management and disposal of health care waste, occupational health and safety of health care workers, and community health and safety related to the operation of health facilities.

31. **The operational support to hospitals and health care facilities through the procurement and deployment of this biomedical equipment will be implemented over a medium-term horizon to strengthen the health system.** Therefore, while it may supplement COVID-19 health care readiness over the medium term, it will not be exclusive to COVID-19 treatment and will be for general health care



services. As a result, attendant adverse risks and impacts related to infection control and transmission are not anticipated to substantiate incremental risks.

32. **The proposed technical assistance (Component 1) activities are anticipated to have generally positive environmental benefits related to HCWM and methane emissions control.** Downstream adverse risks and impact could be anticipated related to implementation of HCWM and emissions control measures as well as proposed public-private partnership measures. This risks and impacts would be expected to be consistent with activities directly supported under the project and are therefore moderate.

33. **The social risk rating of the project is moderate at this stage as the project does not involve any significant social impacts that could harm communities and individuals.** The project footprint is relatively small with limited and manageable adverse social impacts that can be mitigated with the application of appropriate mitigation measures. The likely social impacts include gender-based violence/sexual exploitation and abuse, spread of HIV, and so on, which may result from the limited labor influx and workers coming together in one place during the construction of the operations center. Other impacts may include exclusion of the vulnerable from the project's benefits. The MOH will need to strengthen citizen engagement and beneficiary feedback mechanisms, which will ensure inclusion and active participation of vulnerable groups, as well as its capacity on social risk management and stakeholder engagement, since currently the ministry (through the Department of Environmental Health) has developed its expertise only in environmental risk monitoring.

E. Implementation

Institutional and Implementation Arrangements

34. **Project management.** The project will be implemented by the MOH with the support of an agile PIU. To enhance coordination and ownership, the PIU will be housed within the MOH and integrated in the MOH's operational and management structure. The PIU will report to the Principal Secretary (PS). The primary functions of the PIU will be to coordinate effective implementation of the project and serve as the vehicle for capacity building and skills transfer to MOH staff in the areas of FM, procurement, E&S risk management, and M&E. The PIU will consist of at least seven full-time MOH staff (project coordinator, financial controller, principal accountant, senior procurement officer, M&E officer, E&S officers, supported by a secretary) and seven technical staff to be hired under the project (that is, human capital liaison [1], senior FM specialist [1], procurement officer [1], senior evaluation officer [1], E&S officers [2], and oversight project engineer [1]). The technical support for FM and M&E is for the duration of the project. The human capital liaison would support the MOH for the first 24 months of the operation—a critical time for cross-sectoral coordination and operational planning. The liaison will provide interface between the key human capital components, assuring cohesion with education, social protection, and health. For procurement and E&S management, support is anticipated for the first 18–24 months of project implementation to accelerate implementation and provide sustainable knowledge transfer to MOH staff. To support the E&S development agendas in a sustainable manner, E&S will be integrated at the regional and community levels, using the existing platforms and cadres (for example, regional health inspectors, CHVs, and social accountability officers). The PIU will be headed by a project coordinator, who will facilitate integrated implementation between project components and the activities of the MOH. The project coordinator will support harmonized policy, strategy, and operational processes that span departments/functional areas.



35. For operational efficiency, the PIU technical roles (fiduciary, M&E, and E&S) are shared between this project and the project implementation team for the Eswatini COVID-19 Emergency Response Project (P173883), which was approved on April 20, 2020, and became effective on April 30, 2020. In April 2020, the MOH assigned employees to establish this shared PIU. Sharing MOH staff and technical consultants will improve the strategic scope while reducing the overhead costs across the two projects. Tapping into technical surge capacity early on will accelerate effectiveness. The coordinators for the two projects (P173883 and P168564) will ensure that the project implementation responsibilities are organized to harness operational benefits and reduce operating costs. The two coordinators will present (monthly) project progress to the Senior Management Team of the MOH.

36. **MOH technical leadership.** To strengthen technical capacity in areas that are critical for project effectiveness and to enable and equip the MOH to manage sector modernization, the following departments/units will receive initial technical assistance (surge capacity) to support design and implementation: (a) HRH Unit: one senior technical assistant to support HRH strategy development and implementation and an HRH analyst; (b) Health Services Directorate: primary health care focal team to catalyze primary care revitalization and improve service delivery organization; (c) Health Planning Unit: one senior technical assistant to support health financing/strategic purchasing; and (d) Strategic Information Department: one senior technical assistant to support data flow, data generation, and data analysis for decision making. The assistance will include skill transfer and support transition management. This technical assistant would also provide guidance for the M&E officer in the PIU to ensure robust project evaluation.

37. Project governance beyond the MOH includes an Interministerial Technical Committee, to be convened and chaired by the Director of Health Services, MOH, and an Interministerial Policy Advisory Group that would consist of the PSs of the MOH and central agencies and report to the Secretary to the Cabinet to inform Cabinet and Prime Minister-level engagements.

- **Interministerial Technical Committee** will guide project implementation and its operationalization at the technical level. To avoid creating parallel structures within government administration, this committee will consist of the sectoral officers responsible for health in the Ministries of Finance, Economic Planning, and Development and Public Service, together with their counterparts in the line ministries that are relevant for the project's success—the Director of Health Services, MOH (Chair); the Director of Management Services Division, Ministry of Public Services; the Director of the Ministry of Information Technology—and from ministries related to human capital development. The Interministerial Technical Committee will be convened and chaired by the Undersecretary Technical in the MOH, supported by the human capital liaison, who will provide operational-level coordination between the PIU, the MOH, and other ministries/agencies relevant for human capital development. The liaison will provide a critical interface between the key human capital components, assuring cohesion with education, social protection, and health. The scope of this body will be to review and discuss technical aspects that require coordination with the central agencies and with line ministries and prepare joint reports/proposals for the Interministerial Policy Advisory Group, for its information, guidance, or decision.



- **Interministerial Policy Advisory Group** will consist of the PS of the MOH (Chair), the central agencies, and the chief economist of the Ministry of Economic Planning and Development. The role of this body will be to inform Cabinet-level decision-making and policy formulation, in alignment with Eswatini’s development priorities. The Policy Advisory Group will report to the Secretary to the Cabinet to inform Cabinet and Prime Minister-level engagements. The project coordinator, assisted by PIU staff, will serve as the secretariat for the Policy Advisory Group.

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APPROVAL

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