Project Information Document (PID)

Appraisal Stage | Date Prepared/Updated: 25-Nov-2021 | Report No: PIDA31387

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Project Name	Parent Project ID (if any)
Zambia	P176214	Zambia Emergency Health Service Delivery Project	
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
AFRICA EAST	23-Nov-2021	20-Dec-2021	Governance
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	Republic of Zambia	Ministry of Finance and National Planning	

Proposed Development Objective(s)

To provide emergency support to enable the continued delivery of public health services in Zambia

Components

Emergency financing to enable continued health service delivery
Institutional strengthening of the health sector
Project management

The processing of this project is applying the policy requirements exceptions for situations of urgent need of assistance or capacity constraints that are outlined in OP 10.00, paragraph 12.
Yes

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	155.00
Total Financing	155.00
of which IBRD/IDA	155.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	155.00

IDA Credit	155.00

Environmental and Social Risk Classification

Low

Decision

The review did authorize the team to appraise and negotiate

Other Decision (as needed)

B. Introduction and Context

Country Context

1. **The Zambian economy was already at its weakest point in two decades at the onset of the COVID-19 pandemic.** Growth in 2019 slumped to its lowest in two decades (1.4 percent), with drought conditions impacting agriculture, electricity, and copper production. The expansionary fiscal outturn in 2019, with an overall deficit of 11.5 percent of gross domestic product (GDP), further constricted the country's fiscal space and capacity to swiftly respond to a crisis. Inflation also began to rise above the authorities' target band of 6-8 percent beginning in June 2019, and the Kwacha depreciated by 18.3 percent for the year, thus leading to a tightening of the monetary policy. By 2019, Zambia was assessed to be at high risk of debt distress. Taken together, these macroeconomic pressures led to liquidity challenges by the end of 2019, leading to a build-up in domestic payment and external debt service arrears.

2. **The COVID-19 pandemic considerably worsened Zambia's macroeconomic imbalances.** The economy is estimated to have contracted by 2.8 percent in 2020, marking Zambia's first recession since 1998. Mining and services suffered from lower global demand and social distancing measures earlier in 2020. Inflation remained in the double digits throughout 2020, and it has remained above 20 percent throughout 2021. Falling revenues and COVID-related expenditure pressures worsened the fiscal deficit increase to 16.5 percent of GDP in 2020 compared to an approved target deficit of 6.5 percent. The Kwacha depreciated by over 50 percent while reserves declined to US$1.2 billion at the end of 2020 against at least $1.3 billion in debt service obligations for 2021. The government accumulated over US$800 million in external debt service arrears through December 2020, a clear reflection of increasing debt service pressures. By September 2020, the government had stopped servicing all external debt, except for multilateral debt and some priority projects.

3. **The onset of the COVID-19 crisis fueled Zambia's fall into debt distress.** The World Bank/IMF Debt Sustainability Analysis classified Zambia's debt as at high risk of debt distress and unsustainable by 2019. By Q4 of 2019, Zambia had started building external debt service arrears, which have since accumulated to over US$1.8 billion as of September 2021. Public and publicly guaranteed (PPG) external debt stock reached 96.0 percent of GDP at end 2020 from 66.4 percent in 2019. Severe liquidity shortages and domestic payment arrears persisted in the face of increasing fiscal pressures and a depreciating Kwacha. The authorities initiated a debt restructuring process in early 2020 and hired debt advisors to help them with a comprehensive and orderly debt restructuring. In September 2020, government announced that it would no longer be servicing any external debt except for multilaterals and priority projects. This was followed by a default on Eurobond interest payments in mid-November 2020. Absent debt relief or restructuring, about US$9.4 billion in external debt service obligation on

already disbursed debt would fall due over 2022-24.

4. **Poverty and inequality have increased since the start of the pandemic, with devastating impacts on livelihoods.** The national poverty headcount rate is estimated to have increased from 58.6 percent in 2019 to 60.1 percent in 2020 and is projected to rise further to 60.3 percent in 2021. This increase has mainly been driven by welfare losses in urban areas, and among those relying on employment income from the informal sector. The implication is that in 2021 there will be over 2.5 million more poor people in Zambia than in 2015, of which almost 1 million were added in 2020-21 alone. Correspondingly, livelihoods have been negatively affected in many different areas, including through job/income losses, rising food prices, and reduced access to social services — including health. A recent World Bank survey investigating the welfare impact of the pandemic has shown that more than half of Zambian households experienced a loss of income because of the economic consequences of the pandemic. Eight of every ten households operating family businesses experienced losses through either a reduction in demand, a forced closure, or an inability to access key inputs. Of the almost 2 million school-aged children in the country, around three-quarters received no formal learning between the months of March and September 2020.

5. **The COVID-19 pandemic has also exacerbated inequalities in access to quality health care.** Access to health services was already inequitable across the country, with many poor and rural populations having difficulty in accessing quality care without risk of financial hardship. For example, institutional deliveries for the lowest income quintile were only 72.5 percent of women compared to 95.9 percent in the highest income quintile (DHS 2019). At the same time, 4.8 percent of the poorest were estimated to have experienced catastrophic out-of-pocket expenditures, which is more than double the highest income quintile. The pandemic has also exacerbated existing inequalities because the poor were disproportionately affected by the loss of economic opportunity and increased risk of exposure to the COVID-19 virus. Moreover, they were less able to cope with the consequences. This difference between poor and non-poor households has been particularly stark in urban areas since the start of the pandemic, with 20 percent of poor urban households needing but being unable to access medical care. More broadly though, the urban-rural access disparity is pronounced. For example, 33 percent of urban households with a child under the age of five had access to an under-five clinic in early 2021 as compared to just 22 percent of rural households.

6. **Despite having limited fiscal space, the authorities introduced some fiscal measures to mitigate the impact of the pandemic.** The crisis hit the country when there were no fiscal buffers to cushion its impact. As a result, the authorities put in place some limited fiscal measures — consistent with the constrained fiscal space — to mitigate the economic impact of the crisis. Revenue-reducing measures included suspension of excise duties on some COVID-related medical imports; an allowance of value-added tax (VAT) claims on imported spare parts, lubricants, and stationery; the suspension of import duties on copper concentrates in the mining sector; and suspension of export duties on precious metals and crocodile skins. The government did also not adjust fuel prices and removed VAT and import and excise duties on petrol and diesel in order to rein in inflationary pressures. On the expenditure side, the government issued an eight-billion-kwacha bond (2.4 percent of GDP) to finance increased health spending, arrears clearance, grain purchases, and a recapitalization of a non-bank financial institution (NATSAVE). Capital investment also declined slightly, as a number of projects were halted. These measures contributed to falling revenues and expenditure pressures that have led to increased fiscal deficits in 2020 and 2021.

7. **The new government's proposed 2022 Budget and 2022-24 Medium-Term Fiscal Framework reflect its commitment to ambitious fiscal consolidation while protecting social spending, including increases in health and education spending.** The 2022 budget targets a fiscal deficit of 6.7 percent from a projected deficit of 16.1 percent in 2021, with the related primary fiscal balance improving from a deficit of 7.1 percent of GDP to a surplus

of 1.1 percent. The medium-term fiscal framework targets a primary fiscal balance of 2.7 percent of GDP by 2024, with most of the adjustment coming from reduction in inefficient subsidies (on the Farmer Input Support Program (FISP), electricity and fuel) and in capital spending compression from 7.8 percent of GDP in 2020 to 2.3 percent by 2024, largely driven by cuts in foreign-financed capital spending. On the other hand, the authorities plan to increase spending on social protection from 0.7 percent of GDP in 2020 to 1.1 percent by 2024 and to increase education and health spending, including by hiring over 82,000 additional teachers and medical staff (doctors, nurses, etc.) over the next three years, most of whom will be deployed in rural areas. As a result, health spending is expected to increase from 2.0 percent of GDP in 2021 to 3.1 percent in 2022 and will average 2.8 percent of GDP over 2022-24 compared to 1.9 percent over 2018-20. Education spending is also expected to increase from a budget of 3.3 percent of GDP in 2021 to 4.0 percent in 2022. The government also plans to increase transfers to local governments (including for school bursaries), as part of their broader fiscal decentralization strategy.

8. **Zambia has also requested for debt treatment under the G-20 Common Framework, supported by an IMF program.** The country's participation in the Debt Service Suspension Initiative (DSSI) has helped release resources for the COVID-19 response. The government has also requested debt treatment under the G20 Common Framework, an agreement which could help frame and support the debt restructuring process with all creditors. Restoring Zambia's external debt to sustainable levels will require significant debt restructuring to reduce the present value of debt and support fiscal consolidation.

9. **Beyond restoring macroeconomic stability and debt sustainability, the new administration has also initiated reforms to promote private sector-led sustainable recovery and growth.** In this respect, the government has targeted reforms in various sectors, including agriculture, mining, energy, and tourism, to jumpstart growth. In the agriculture sector, the government plans to improve the efficiency and effectiveness of the Farmer Input Subsidy Program (FISP), incentivize large-scale commercial farming, and improve irrigation-based farming. In the mining sector, the government targets an increase in mining production from the current 800 thousand tons per annum to 3 million tons per annum in the next decade by, among others, making the mining fiscal regime more predictable and in line with international practices and promoting local artisanal mining. In the energy sector, the government intends to improve the cost efficiency and financial sustainability of the public electricity company, ZESCO; and to improve energy mix in a way that responds to climate change risks by implementing its Renewable Energy Investment Plan. Lastly, the government intends to support the recovery and sustainable growth of the tourism sector following its devastation from the COVID-19 crisis through various fiscal incentives (for example, extending the corporate income tax rate of 15 percent for hotels and lodges to December 2022 compared to the standard rate of 30 percent) and infrastructure investments.

Sectoral and Institutional Context

10. **Zambia has made improvements in key health outcomes over the past two decades, but significant challenges remain.** Between 2000 and 2019, the under-5 mortality rate (U5MR) fell from 152 to 62 deaths per 1,000 live births, and the maternal mortality ratio dropped from 528 to 213 deaths per 100,000 live births. The prevalence of stunting among under-5 children also declined from 59 percent in 1999 to 35 percent in 2018. Despite these gains, access to health and nutrition services in Zambia remains low. Thus, the U5MR and stunting rates are still comparatively high, and above the average for lower-middle-income countries. The national total fertility rate (TFR) average of 4.7 children per woman is also high. Furthermore, it is even higher in rural areas, with 5.8 children per woman as compared to 3.4 children per woman in urban areas. Communicable, maternal, neonatal, and nutritional diseases remain the leading causes of death and disability in Zambia. However, non-communicable diseases have been rising rapidly. Currently, they account for 23 percent of mortalities. There are also inequities in the utilization of healthcare by income status, age, education, and geographical location. In response to the current crisis, it is now paramount to avoid reversal of progress.

11. **Investments in more highly qualified health professionals have contributed to improved service delivery, but additional health workers are required — especially during the ongoing pandemic.** Most of the new recruitments are for skilled health professionals (doctors, clinical officers, nurses, and midwives). Their numbers have increased by 143 percent, that is, from 12,925 in 2010 to 31,361 by the end of December 2020. Consequently, there has been an increase in the share of births attended by skilled health professionals from 64.2 percent in 2014 to 80.4 percent in 2018. About 71 percent of these deliveries were attended by a nurse/midwife and 8 percent by a medical doctor in 2018. Better access to skilled birth attendance has plausibly contributed to a reduction in the maternal mortality ratio from 591 to 278 deaths per 100,000 live births between 2007 and 2018, respectively. However, relating the number of skilled health professionals to the population shows that there are only 17 skilled health professionals per 10,000 population. This is below the required density of 34.5 skilled health professionals per 10,000 population. In addition, notwithstanding the increased number of medical doctors in-post, Zambia has only 0.2 doctors per 1,000 people. This is far below the average of 0.7 doctors per 1,000 people for lower-middle-income countries. Shortages in the number of medical doctors are particularly high in rural areas. Generally, about 70 percent of all medical doctors work in the predominantly urban provinces (Copperbelt, Lusaka, and Southern), whereas the rest of the country — which consists mainly of rural provinces — has the remaining 30 percent of doctors. As a result, a doctor in the Eastern or the Luapula province sees twice as many hospitalized patients as a doctor in Lusaka. Therefore, continued investment in core health workers is still critical, especially given the ongoing COVID-19 pandemic.

12. **The continuing debt crisis, coupled with the COVID-19 pandemic, are threatening to reverse progress made in health outcomes.** As a result, there is an increased pressure on the government's ability to quickly finance the continued provision of core health services. Zambia is in its second wave of the COVID-19 outbreak, which is characterized by high transmissibility, geographical spread, disease severity (requiring hospitalization and oxygen therapy), and death. The cumulative number of positive cases and deaths increased from 17,916 and 364 deaths as of December 7, 2020 (that is, toward the end of the first wave) to 207,560 and 3,623, respectively, as of September 10, 2021. Since the start of the second wave, COVID-19 cases have been reported in almost all districts in the country, with the districts in Copperbelt, Lusaka, and the Southern provinces reporting the highest number of cases and deaths. Considering that most of the new COVID-19 cases during the second wave are being locally transmitted, the virus has been rapidly spreading in communities. Though the number of positive cases has recently started coming down, as a result of the increase in the number of people getting vaccinated, the risk of widespread infections remains high due to limited capacity in terms of pandemic preparedness and response, as well as a general disregard of public health measures to combat the outbreak — including physical distancing, avoiding large social gatherings, and the wearing of masks in public places. The ongoing pandemic has put intense pressure on the health system, especially on the health facilities at the district and provincial levels, which are ill-prepared to cope with the increased demand for health services arising from the pandemic, over and above the regular demand for public health services.

13. **Sustained financial support is critical for the continued delivery of health services, especially in the rural areas, and the government has committed to maintain per-capita health spending.** Per capita government healthcare spending increased over the past decade, reaching US$33.6 in 2017. The current crisis has led to a significant contraction to US$24.6 per capita in 2020. Projections to 2025 are even more grim if the health share of the budget were to be kept constant at the 2018-2020 average, falling to about US$12.7 per capita. This would be less than half of the US$30.1 per capita spending that was projected if the pre-COVID trend were continued and would fundamentally erode the health sector's capacity to deliver health services. To counteract this, the government has made clear commitments to maintain health sector per capita allocations in its medium-term expenditure framework and protect essential spending from other fiscal consolidation measures and keep up with high population growth. In this light it is expected that the government will reprioritize health in the budget

from 6 to about 11 percent of general government expenditures by 2025. The World Bank financed operation will provide the necessary fiscal space for government to bridge short term constraints and enable timely budget releases to allow the health sector to provide critical primary health care services, especially in the rural areas.

14. **Expenditure cuts have already led to delays in health sector payments and an underfunding of the recurrent budget, thus imperiling health service provision during a global pandemic.** The increasingly difficult fiscal situation has led the government to ration cash disbursements to sector ministries and delay payments. In the health sector, this has already translated into delaying payments to staff. There are also other related arrears, such as allowances for settling-in, night-duty, transport, meals, and operational travel. Beyond human resources, there is also anecdotal evidence of arrears for payments for electricity, fuel, and food supplies for in-patients, as well as for drugs and medical supplies. In addition, the Ministry of Finance has not remitted National Health Insurance Management Authority (NHIMA) payments for health insurance for some months. The extent of these problems is still being estimated; however, the adverse effect on service delivery is already becoming evident.

15. **An increasing share of government healthcare spending is allocated to salaries and wages, but delays in salary payments can negatively affect the morale among staff, encouraging absenteeism and the solicitation of informal payments.** Such delays are also detrimental to healthcare outcomes during the pandemic. In recent years, government expenditures for salaries and wages in the health sector increased significantly as a share of total health spending, from 48 percent in 2010 to 84 percent in 2019 (Table 1), with staff numbers reaching 62,802 by December 2020. Absenteeism and tardiness among health workers at public health facilities in Zambia is estimated to amount to the equivalent of a loss of 11.5 full-time staff per month. The average in-patient caseload per doctor was estimated at about three patients per day, which is low and indicative of absenteeism. Health worker absenteeism is in turn associated with reduced health care-seeking behavior of patients in the public sector. Paying salaries and wages in full and on time will prevent health professionals from experiencing financial hardship during the crisis. It will also reduce incentives for health workers to charge informal fees to patients, which would exclude poor people from treatment. Despite the removal of medical user fees in the public health sector in Zambia, patients still incur informal charges at public health facilities. Such informal payments can undermine public confidence in the public health sector.

16. **Delays in salary payments also disproportionately affect women because they comprise a large share of the health workforce in Zambia.** Zambia's Gender Inequality Index (GII) is 0.536, with a ranking of 137 of the 162 countries considered. This is driven by poor performance in reproductive health, empowerment, and economic activity. Female participation in the labor force is 70.4 percent compared to 79.1 percent for men. This figure was buoyed by the disproportionate participation of women in the health workforce. The share of female nurses increased from 75.6 percent in 2010 to 82.2 percent in 2018. Thus, delays or shortfalls in health workforce salary payments will disproportionately affect women. If payments are not protected, this will affect their household bargaining position, place in society, and educational attainment of their children. Furthermore, it will make female-headed households more susceptible to poverty.

17. **The increase in the health budget from 2022 reflects the new administration's drive to address the severe shortage of health sector workers including through filling existing vacancies, estimated at 44 percent in 2020.** The draft 2022 budget and 2022-24 fiscal framework shared with the World Bank shows that the government intends to increase social sector spending, including in health and education. Under this fiscal path, the new government intends to recruit more than 11 thousand new health workers in 2022, including over 800 doctors, and 30,000 new teachers. This includes over 800 medical doctors, at an estimated cost of about US$50 million; with new recruitments over 2023-24 projected to add another US$50 million. Correspondingly, non-salary health expenditure is also expected to increase to provide for the increased access to other essential health inputs (drugs, routine vaccines, and medical supplies; infrastructure maintenance; operational expenses etc.).

C. Proposed Development Objective(s)

Development Objective(s) (From PAD)

To provide emergency support to enable the continued delivery of public health services in Zambia.

Key Results

a) Number of first outpatient department (OPD) visits
    a. Of which are women
b) Number of women attending antenatal care in first trimester
c) Number of deliveries supervision by skilled personnel
d) Number of childhood immunizations provided (measles)

D. Project Description

Component 1. Emergency financing to enable continued health service delivery (US$150 million)

18. **This component will provide emergency financing support to the Government of Zambia to finance the continued delivery of essential healthcare services.** The government will use the financing provided under this component to meet the costs of health service delivery such as salaries of health workers (doctors, clinical officers, midwives, nurses, paramedics, and other frontline health workers) already on the payroll at provincial and district levels. This includes staff at District Health Offices, District Hospitals, Health Centers, Health Posts, Provincial Health Offices, and referral hospitals. By protecting salaries of essential health workers women, who comprise most of the health workforce, will be directly protected from associated risks and a further deterioration of the GII. These workers provide services at the district health facilities, such as District Hospitals, Primary Health Centers, and health outposts, as well as at the Provincial Health Offices, including specific health programs (such as immunizations, malaria prevention) and referral hospitals. The project does not finance the cost of medical items such as vaccines, prescription drugs, equipment or construction that will continue to be financed by the government budget as well as through projects financed by cooperating partners including the World Bank.

19. **The project will result in the continued provision of core health services at the district and facility levels.** Staff at district health facilities, such as District Hospitals, Primary Health Centers, and health outposts, play a critical role in providing primary health care (PHC) services to citizens, especially at the last mile. PHC is a whole-of-society approach to health that aims to ensure the highest possible level of health and well-being and the equitable distribution of services by focusing on people's needs as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation, and palliative care, and as close as feasible to people's everyday environment (WHO and UNICEF). The financing under the project will be utilized to provide PHC services such as, but not limited to: (a) maternal and child health care services; (b) malnutrition prevention and treatment; (c) Integrated Management of Childhood Illness (IMCI); (d) treatment of communicable diseases; and (e) prevention, early detection and management of non-communicable diseases. Provision of PHC services is a critical component of the efforts to achieve Universal Health Coverage (UHC). The financing provided by the project will enable the government to meet the salaries and wage costs relating to front-line health service delivery in the districts and facilities. The funding provided under this component will not be used for meeting the expenditures relating to the COVID-19 pandemic as these expenditures are being financed through another operation.

20. **The project will also finance service delivery costs at the at the Provincial Health Offices (PHO)**. The PHO

staff are responsible for the implementation of vertical health programs (such as immunizations, malaria prevention) as well as the provision of inpatient and outpatient care at referral hospitals. This component will finance the costs of health service delivery at the provincial level. Estimations made based on the recurrent cost budget (salaries and wages) at the provincial and district levels for the past three years show that the project will finance approximately 28 percent of the MoH's recurrent cost budget for provinces and districts for the duration of the project, during 2022 and 2023. The project will not finance wages of the central Ministry of Health administrative staff, or contractual staff hired by various health facilities who are paid by a facility's own-source revenues and/or other development partners.

21. **The project will be implemented collaboratively by the MoFNP and MoH.** The financing provided by the project will be used by the MoFNP to ensure that the wage bills for frontline staff in the districts and provinces are paid on a regular and timely basis. The technical capacities of health personnel in Zambia have been found adequate for delivery of essential health services. The support provided by the project will complement the existing financing of salaries and wages and will enable the MoH to ensure that health facilities at the provincial and district level responsible for service delivery are adequately staffed with health workers with the required technical qualifications. The Senior Management headed by the Permanent Secretary (Administration) and the Permanent Secretary (Technical) at the MoH will use their existing HR Management systems to make sure that facilities are staffed with adequate health workers. The delivery of primary health services at the district and provincial levels is supervised by the MoH through its established supervisory structures at the central, provincial and district levels. This will enable the MoH to achieve the key indicators relating to primary health service delivery that will be tracked through the project's results framework. The Project Management Unit (PMU) will carry out a service delivery assessment at the beginning and towards the end of the project to ensure that primary health service delivery has improved or been maintained. The project Technical Committee, responsible for monitoring of project results and outcomes and providing directions to the PMU will have adequate representation from the MoH. The PMU will include as part of its core staffing a public health specialist, preferably on secondment from the MoH, to coordinate and monitor the health service delivery outcomes intended to be achieved by health workers through the financing provided by the project.

22. **The project will put in place a robust control and oversight framework to ensure that the financing is used to meet eligible expenditures.** A detailed review of MoH salary and allowance expenditures, as well as a comparison with PSMD salary and allowance expenditures for health, has been carried out by the Office of the Auditor General (OAG). The resulting report will be shared with the World Bank and its recommendations will be used to strengthen the project's fiduciary assurance framework**.** This review will confirm whether the expenditures are eligible and meet the agreed control procedures, including processing through the PMEC System. The review is being conducted as part of project preparation, and it will continue during project implementation. In accordance with the existing system of paying civil service salaries, the monthly salaries will be disbursed to eligible civil servants in the MoH through direct deposits to their individual bank accounts. There will be an independent external audit of the project as well as internal audits as part of the project's fiduciary arrangements.

Component 2. Institutional strengthening of the health sector (US$ 4.5 million)

23. **This component aims to strengthen processes for efficient resource management and expenditure control and contribute to enhancing the efficiency of underlying PFM systems and processes in the health sector.** The activities envisaged under this component do not purport to directly change sector outcomes. Rather, they should be viewed as necessary actions that function as building blocks for better service delivery outcomes. This component establishes resource management preconditions for improving the quality of services delivered. Significant improvements in health service delivery and health outcomes will require additional actions and

programs in the medium term. The support provided under this component will complement other sectoral programs, including World Bank operations in the health sector. Eligible Expenditures under this component will include the goods, and consultancy services necessary for implementing the component activities.

24. **Strengthened Public Financial Management Practices in the Health Sector.** This component aims to strengthen budgeting, financial reporting, and procurement practices in the health sector. The MoF has implemented an Integrated Financial Management Information System (IFMIS) (based on SAP ECC 6.0 EHP 8) for budget management, cash management, and financial reporting, with coverage limited to Ministries, Provinces and Agencies (MPAs). Due to the delays in rolling out IFMIS to the districts, some sectors have implemented different Financial Management Information System (FMIS) solutions to support their sector-specific functions that IFMIS cannot support due to cost and design. The MoH is using MS Navision (2017 version) Finance, Payroll, Procurement, and Asset modules in the Eastern and Southern Provinces through assistance from Cooperating Partners. Currently, due to the fragmentation of reporting, it is difficult for stakeholders within and outside of the government to obtain an accurate picture of health sector expenditures, both in the aggregate and at the level of service delivery. As a result, the central government is not able to track health sector expenditures at the provincial and district levels. This component will provide support to the MoF and MoH to enable the interoperability between the different FMIS used in the health sector by developing suitable interfaces between the MoF's SAP-based IFMIS and the MoH's MS Navision system. The existing Government Service Bus (GSB), which was launched by the Smart Zambia Institute in June 2020 to improve the interoperability of government systems and the provision of online public services, will be used to automate daily data exchange between the SAP and the MS Navision systems using Application Programming Interfaces (APIs). The MoF has experience using the GSB to exchange data with other systems (e.g., Zambia Revenue Authority, Zambia Immigration System). Based on these experiences, existing systems can be connected through the GSB rapidly and cost-effectively, and it will help to record and report health sector expenditures with desired frequency. The component will support the MoF and MoH to prepare the technical design solutions for enabling the interface between the two systems as well as implement the solution through the necessary technical studies, consultancies and support for any software and hardware upgrades, as necessary.

25. The MoF and the MoH are currently assessing the IFMIS in the health sector and will implement a strategy for the coordinated upgrade and rollout of FMIS solutions in the sector. To achieve this, the existing MS Navision systems need to be upgraded to the latest version and rolled out to all districts to track specific health sector (and other sector-specific) expenditures especially at the facility level. The project will also support the roll-out of the FMIS upgrade to those districts and facilities that are not connected to the existing FMIS (MS Navision) solutions on a pilot basis. Budgeting and cash management practices as well as strengthened procurement practices in the sector will be supported through targeted technical advisory support and training. This will enable efficient and effective budget utilization; accurate and timely accounting and reporting; and effective control, scrutiny, and review of public expenditures in the health sector at the national and sub-national levels. Support provided will include consultancy support for design and technical advice, procurement of software and hardware as necessary.

26. **Improved Payroll Management in the Health Sector**. Skilled human resources available at the point of service delivery are critical to the achievement of health sector outcomes. The PER (2018) found that the human resource gap is greatest in rural areas, which have about one core health worker per 1,000 people as compared to two core health workers per 1,000 people in urban areas. Furthermore, there is an imbalance in the skills mix, particularly for doctors, which are in short supply in rural areas. Several OAG reports have referred to the mismatch between accounting records and headcounts, posing a fiduciary risk to the wage bill system. This component will support the MoF and MoH to strengthen payroll management in the health sector through a

payroll audit of the Ministry of Health at all levels and validation of the payroll. The payroll audit may be carried out either by Government agencies and/or with the support of consultants. The findings of the payroll audit will be published and the MoF and MoH will take steps to address the audit findings and recommendations expeditiously. The payroll audit will be helpful to the MoH to develop a long-term Human Resource Management strategy for the sector.

27. **Analytical Studies and Training.** This component will contribute to strengthening of fiduciary and safeguards practices in the health sector through targeted training and advisory support. The project will also support analytical studies relating to strengthening the financial sustainability of the health sector and introducing improved sector financing strategies, as necessary.

Component 3. Project management (US$0.5 million)

28. **This component will finance the operating costs of the Project Management Unit (PMU), including salaries, consultant fees, and other operating costs required for the implementation of the operation.** The PMU will organize spot checks and payroll verification measures to ensure that the project funds are used for their intended purposes. This component will also finance independent audits to provide adequate fiduciary assurance on the use of project funds. The PMU will also contract the services of an independent entity to verify the continued provision of health services at the primary and secondary health 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

29. **The social risk is Moderate.** The project is not financing activities that involve land acquisition, restrictions on land use, or involuntary resettlement. The project will enhance resource management in the health sector, contributing to better service delivery, and enhanced accountability and transparency. However, there is a potential for moderate social risks, such as the exclusion of vulnerable and minority groups, issues pertaining to labor and working conditions, and stakeholder and citizen engagement risks. The project activities will be conducted mainly by the MoF and MoH staff, who are government civil servants. Civil servants from the MoF and the MoH will work in connection with the project, either full- or part-time. They will remain subject to the terms and conditions of their existing public sector employment or agreement. Environmental and Social Standards (ESS) 2 (Labor and Working Conditions) will not apply to such government civil servants, except for the provisions of paragraphs 17 to 20 (Protecting the Work Force) and paragraphs 24 to 30 (Occupational Health and Safety, OHS), which fall under the provisions of workers' safety, as outlined in ESS 2. The OHS measures that apply to the project will be contained in the legal agreement and the Environmental and Social Commitment Plan (ESCP). Risks will be addressed through the preparation and implementation of the Stakeholder Engagement Plan (SEP) as part of the ESCP. They will be updated, as and when necessary, during implementation. As committed in the ESCP, the environment and social risks of the project will be managed by appointing a designated focal person (an

environmental and social safeguards specialist) within the PMU, who can be supported or trained by the World Bank's environmental and social specialists.

30. **The environmental risk is rated Low, with no relevant Environmental and Social Standards (ESS).** The project is not expected to generate pollution to the air, water or land, or consume any finite natural resources. Pollution prevention management and impacts on human health and the environment are not required or expected. There will be no occupation of land for any project activity. Therefore, the project will not impact on biodiversity conservation or interfere with sustainable management of living natural resources. There will be no impact on tangible or intangible cultural heritage. The project is not financing activities that involve infrastructure or equipment, therefore there is no community exposure to any project risks or impacts. The project will likely have a positive impact on the environment by enabling financing of recurrent costs that will help ensure the continuation (on an emergency basis) of current programs and operations that include essential medical infrastructure maintenance, such as incinerators, autoclaves, as well as sound infectious waste management practices. There are several planned or ongoing World Bank projects associated with the MoH, all of which require or will require a moderate level of continued environmental interventions within their various sub-projects. This project is expected to indirectly support the maintenance of these current and proposed interventions. There are no direct tangible environmental outcomes from this project. Thus, no significant or irreversible environmental impacts are expected. However, negative, indirect OHS impacts could materialize within the MoH working environment, if budgetary constraints affect the implementation of effective COVID-19 control measures, or if the initial stakeholder engagement methodology relies on face-to-face meetings. The indirect benefits of the project will be closely monitored by the World Bank team with the project's environmental and social focal point to ensure that such benefits materialize.

E. Implementation

Institutional and Implementation Arrangements

31. **The Ministry of Finance will be the implementing agency, responsible for the overall coordination of planning, implementation, and monitoring of the project.** The MoH will be a key stakeholder responsible for delivering public health services and ensuring achievement of results, working in close collaboration with the MoF. Other key stakeholders such as the OAG and the Zambia Public Procurement Authority (ZPPA) will provide support. The project is fully integrated and mainstreamed in the current structure of the government, and no parallel structures will be created outside of government for the purposes of project implementation. This arrangement has been adopted to ensure ownership and sustainability. The Project Management Unit (PMU) is anchored within the PFM unit in the Accountant General's Office. The unit has successful experience in implementing a previous multi-donor financed and World Bank-led PFM Reform Project. The PMU staff will include: (i) a project coordinator; (ii) a monitoring and evaluation (M&E) specialist; (iii) a financial management specialist; (iv) a procurement specialist; (v) an environmental and social safeguards specialist; and (vi) a public health specialist. Other specialists may be hired as necessary during project implementation. The fully staffed PMU will be in place by project effectiveness.

32. **The PMU will be responsible for managing the day-to-day operations of the project.** Its main functions include: (i) providing logistical support and guidance; (ii) compiling work plans, budgets and procurement plans; (iii) monitoring project implementation and preparing progress reports; (iv) submitting consolidated annual work plans, and budget and procurement plans for review and endorsement; (v) maintaining project accounts, managing designated accounts and preparing project financial statements; (vi) submitting withdrawal applications to the World Bank for replenishment; and (vii) making recommendations to the committees on how to effectively implement the agreed work plan. The substantive leadership for the project activities will be

provided by the MoF and the MoH through a Project Steering Committee, as well as through a Technical Committee (see below).

33. **A Project Steering Committee will provide strategic direction, overall coordination, policy guidance and oversight.** The PSC will be chaired by the Secretary to the Treasury (ST). The members of the PSC will include: (i) the Accountant General; (ii) the Permanent Secretary of Budget and Economic Affairs; (iii) the Permanent Secretary of the Economic Management Division (EMD) at the MoF; (iv) the Controller of Internal Audit; (v) the Permanent Secretary of Administration at the MoH; and (vi) the Permanent Secretary of Technical Services at the MoH. The PMU will serve as the Secretariat to the PSC, and it will be responsible for organizing the meetings of the PSC based on the directions received from the Chair.

34. **A Technical Committee chaired by the Accountant General will provide routine oversight and technical guidance during project implementation.** The Technical Committee is responsible for ensuring that the implementation of the project is carried out efficiently and with the necessary technical quality. The members of the Technical Committee will include: (i) a Project Coordinator; (ii) the Director of PMEC at the MoF; (iii) the Director of Financial Reporting and Information Systems at the MoF; (v) the Director of Treasury Services at the MoF; (vi) the Director of the EMD at the MoF; (vii) Director of Human Resource Administration (HRA) at the MoH; (viii) the Director of Finance at the MoH; (ix) the Director of Budget at the MoF; (x) the Director of Planning at the MoH; (xi) the Director Investment and Debt Management (IDM) at the MoF; (xii) the Director of Public Health at the MoH; (xiii) the Heads of Procurement at the MoF and MoH; (xiv) the Director of Internal Audit at the MoH; (xv) the Director of Specialized Audits at the MoF; and (xvi) the Director of Policy, Research and Standards (PRS) at the MoF. Representatives from line ministries and other relevant officials will participate in meetings, as necessary. The Committee will meet initially every month for the next three months after project effectiveness, and thereafter quarterly. It reports to the PSC, and it will ensure that implementing teams comply with agreed policy guidelines. The Committee can also call technical meetings with the participation of other project representatives to discuss issues of a cross-cutting nature and interface with the project, as and when required.

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