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

Appraisal Stage | Date Prepared/Updated: 03-Jun-2020 | Report No: PIDISDSA29089

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Project Name	Parent Project ID (if any)
Zimbabwe	P173132	Zimbabwe Health Sector Development Support Project - Additional Financing V	P125229
Parent Project Name	**Region**	**Estimated Appraisal Date**	**Estimated Board Date**
Health Sector Development Support Project	AFRICA	15-May-2020	15-Jun-2020
Practice Area (Lead)	**Financing Instrument**	**Borrower(s)**	**Implementing Agency**
Health, Nutrition & Population	Investment Project Financing	Republic of Zimbabwe	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 ruraldistricts consistent with the Recipient's ongoing health initiatives.

Proposed Development Objective(s) Additional Financing

Improve coverage and quality of an integrated package of Reproductive, Maternal, Neonatal, Child, Adolescent health and nutrition (RMNCAH-N) services, as well as strengthen COVID-19 response and institutional capacity to manage performance-based contracts consistent with the Recipients' ongoing health initiatives.

Components

Delivery of Package of Key Reproductive, Maternal, Neonatal, Child, and Other Related Health Services
Management and Capacity Building
Monitoring, Documentation, and Verification of Results under Performance-based Contracts
COVID-19 Response

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	54.90
Total Financing	54.90
of which IBRD/IDA	0.00
Financing Gap	0.00

DETAILS

Non-World Bank Group Financing

Counterpart Funding	29.90
Borrower/Recipient	29.90
Trust Funds	25.00
Global Financing Facility	25.00

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, a landlocked[1] and lower-middle income[2] country with a gross national income per capita of US$1,790 (Atlas method, 2018) and a population of 14.4 million (WDI 2019), was already facing a deep economic and humanitarian crisis prior to the COVID-19 pandemic**. Slow reforms, policy missteps, and devastating climate shocks rendered around 50 percent of the population food insecure. Extreme poverty has more than doubled since 2011, reaching approximately 6.6 million people in 2019. The Government of Zimbabwe (GOZ) has made progress on fiscal reforms and reduced unsustainable fiscal deficits but at the expense of rapid deterioration of basic service delivery (health, water and sanitation, social protection, and education). Monetary and foreign exchange market reforms have not been effective, and inflation reached 676 percent (year-on-year) in March 2020 while international reserves are very low. Gross Domestic Product (GDP) is estimated to have contracted by 8.1 percent in 2019 after growing by close to 4.7 percent in 2017 and 2018. (IMF 2020). It is projected to contract by 10 percent in 2020 due to another projected poor harvest, foreign exchange shortages, price instability, and significant supply and demand shocks from measures to contain the spread of COVID-19 (WB 2020). While the 2020 budget includes a significant nominal increase in social and health allocations, inflationary pressures and the COVID-19 pandemic are likely to render allocations insufficient if not addressed in a timely and strategic manner.

[1] The country borders Botswana, Mozambique, South Africa, and Zambia.

[2] In 2018, the Government rebased GDP and Gross Domestic Income figures which changed its economic status from low-income to lower-middle income.

Sectoral and Institutional Context

2. **Zimbabwe has made commendable improvements in key health outcomes in the past decade, but progress was not fast enough to meet the country's 2015 Millennium Development Goals and current projections fall short of its Sustainable Development Goals (SDGs)**. Zimbabwe's human capital index[3] is 0.4, which is on par with the Southern African Development Community average.[4] The country's Maternal Mortality Ratio, a key indicator of the status of the nation's health system, has dropped from 651 in 2015 (ZDHS) to 462 maternal deaths per 100,000 live births (MICS 2019), but remains high and ranks poorly relative to peers in the region. Under-five mortality has also decreased but remains high at 78 per 1,000 live births (MICS 2019). HIV and TB prevalence have both declined. While underweight in under-five children increased from 8.4 percent in 2015 (DHS 2015) to 9.7 percent in 2019, stunting decreased from 26.8 percent in 2015 (DHS) to 23.5 percent in 2019 (MICS 2019). Neonatal mortality has remained at 32 per 1,000 live births for the past 10 years (MICS 2019). The draft Health Sector Investment Case (HSIC) situation analysis found that maternal mortality and neonatal mortality were highest at central and provincial hospitals. The National Health Strategy 2016-2020[5] Mid-term Review/NHS MTR (2019) and Maternal and Perinatal Death Notification, Surveillance and Response reports (2018) noted that quality of care and staff motivation were responsible for most of the deaths. In addition, the draft HSIC and NHS 2016-2020 MTR also identified gaps in community level interventions as a major cause of slow progress of antenatal care and child health indicators. Zimbabwe is also increasingly challenged by the dual burden of communicable and non-communicable diseases. Access to health services and subsequent outcomes have largely been inequitable with poor and rural populations shouldering a disproportionate burden of disease and health expenditures.

3. **Zimbabwe's cycles of fragility and macroeconomic challenges compounded by recent climatic shocks have led to cash shortages and high inflation affecting health providers' ability to execute planned activities.** To compensate for long-term under-investments in the health sector, the GOZ increased its health sector budget by at least 40 percent, adjusted salaries, provided additional allowances, offered housing and vehicle loans to staff in 2019. However, these efforts fell short of inflation rates that reached 522 percent by end 2019. Worsening economic conditions since 2019 have strained the health workforce and reversed progress made since 2012. Although the overall health worker vacancy rate declined from 17 percent in 2014 to 10 percent in 2019, inflation eroded salaries and significantly reduced availability of key supplies and equipment, resulting in a demotivated health workforce. In the second half of 2019, over 500 junior doctors went on strike while nurses reduced their working hours.

4. **Inefficiencies in budget execution and resource management also contribute to limited resources for key interventions**. While results-based financing (RBF) has contributed to improved results and accountability among participating health facilities, the Joint Needs Assessment[6] (2019) and draft HSIC note inefficiencies in sector governance including public finance management such as budget preparation and execution, procedures, transparency and accountability. Budget execution is affected by fund disbursement delays by the Ministry of Finance and Economic Development (MOFED) and procurement delays at the Ministry of Health and Child Care (MOHCC) level, among other constraints. The 2018 health sector resource mapping exercise notes that of the US$966 million health budget, almost 60 percent came from domestic resources while the remaining 40 percent came from external sources. At least 80 percent of domestic resources went to health worker salaries while external funding was earmarked for specific disease programs with nearly 50 percent toward medicines. The limited economic growth prospects in 2020 also underscore the importance of continuing to explore options to lower implementation costs and improve health spending efficiency.

5. **Recent reviews have identified health sector challenges that are likely to be exacerbated by the COVID-19 pandemic**. The 2018 Joint External Evaluation (JEE) on International Health Regulations and the 2019 NHS MTR identified capacity gaps in emergency preparedness, infection prevention and control, public health response capacity at points of entry, health sector coordination; sector financing; design of interventions; implementation effectiveness;

availability and use of data; and availability of human resources for health and essential health commodities. It is also important to note that Zimbabwe's health system was further weakened by the doctors' strike as well as reduced working hours of nurses in 2019. Moreover, at the outset of 2020, there were only 14 functional intensive care units in Zimbabwe with most of them located in private health facilities. All district hospitals and most provincial hospitals do not have functioning oxygen therapy equipment which is critical for severe respiratory illnesses including COVID-19. In sum, the health sector is ill-equipped to deal with COVID-19 let alone manage the normal disease burden. In addition, (i) all of Zimbabwe's immediate neighboring countries are reporting increasing numbers of cases; ii) local transmission has been reported in Zimbabwe and its neighboring countries; and (iii) a growing number of deportees or returnees from neighboring countries to Zimbabwe will add to the disease burden and likely increase COVID transmission. As of June 2, 2020, the number of Sub Saharan Africa (SSA) countries with reported cases had reached 47 with 105,948 cases and 2,675 reported deaths (WHO) while Zimbabwe had confirmed 206 COVID-19 cases and four deaths.

6. **The GOZ has elaborated a coronavirus national plan in a consultative manner**. The MOHCC's national COVID-19 National Preparedness and Response Plan, launched on March 19, 2020, is aligned with WHO guidance and includes all recommended pillars. The National Emergency Operations Committee (EOC) has been established with 8 committees working on the 8[7] pillars of the National COVID-19 plan. The President also established an Inter-Ministerial Committee which provides oversight to the response. Through this Committee, an additional pillar on Security has since been introduced. All Provincial and City Rapid Response Teams have been activated for COVID-19; these also assist in surveillance of travelers from COVID-19 affected countries. Isolation hospitals have been designated at Wilkins Infectious Diseases Hospital and Thorngrove Infectious Diseases Hospitals in Harare and Bulawayo, respectively. MOHCC has also identified infectious diseases hospitals in Kadoma, Mutare, Masvingo and Gweru as sites to set up isolation centers for testing and treatment of COVID-19 cases. The GOZ introduced national public health measures to contain the spread of the pandemic, including mandating a national lockdown starting March 30, 2020. While the GOZ partially eased restrictions since May 18, the country remains generally in lockdown with exemptions for specific industries such as banking and manufacturing, as well as some low-risk activities such as jogging and cycling.

7. **Implementing Zimbabwe's COVID-19 response plan requires significantly more resources than are currently available.** The Government allocated ZWL 100 million (US$4 million equivalent, using the official exchange rate of ZWL 25 to 1 USD as of March 27, 2020) to the MOHCC. It represents almost 1.2 percent of the COVID-19 response budget of US$334 million. Since the estimated 3.5 percent deficit as a share of GDP in 2019 is projected to increase to 5 percent in 2020 (IMF 2020), the GOZ is unable to allocate additional resources to the national COVID-19 pandemic preparedness and response. To support the MOHCC's preparedness and response actions, partners such as WHO, Global Fund through the United Nations Development Program, the Health Development Fund (HDF) through the United Nations Children's Emergency Fund (UNICEF) as well as private sector players[8] are providing immediate support in the following key

[3] The World Bank Group's (WBG) Human Capital 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.
[4] SADC is a regional organization comprised of 14 member countries.
[5] The National Health Strategy (NHS) 2016-2020 aims to provide access to quality and equitable health services to Zimbabweans, with a specific focus on achieving the SDGs directly related to health.
[6] The Joint Needs Assessment was prepared jointly by the Africa Development Bank, UN, and WBG in collaboration with the MOHCC.
[7] Pillars: (a) Coordination, planning and monitoring; (b) Risk communication and community engagement; (c) Surveillance, rapid response teams and case investigation; (d) Points of Entry; (e) National laboratory system; (f) Infection prevention and control; (g) Case management and continuity of essential services; and (h) Logistics, procurement and supply management.
[8] Total value of pledges is US$69.7 million as of May 5, 2020. Significant funding gaps remain especially with regard to hazard pay for health workers and rapid response teams. The private sector has provided in-kind support, but information is not readily available on type of support and estimated value.

areas: capacity building in case management, infection prevention and control, essential laboratory supplies, procurement of personal protective equipment (PPE), development of public communication materials, and multi-sectoral risk communication. Other partners, such as Gavi, the Vaccine Alliance, have agreed to reallocate a portion of existing grants to COVID-related activities. The Government requested the World Bank (WB) for support. However, Zimbabwe's non-accrual status in the WB makes it is unable to access the WB's Fast Track COVID-19 Facility (FTCT) which was approved on March 12, 2020 to help WB client countries to respond to the global COVID-19 outbreak. Given Zimbabwe's special situation, the Global Financing Facility (GFF) in support of *Every Woman Every Child Initiative* agreed to allocate US$5 million of the proposed US$25 million grant for COVID-19 response activities, as part of the proposed fifth Additional Financing (AF V) for the ongoing Health Sector Development Support (HSDS) Project (P173132).

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 ruraldistricts consistent with the Recipient's ongoing health initiatives.

Current PDO

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

Key Results

1.	Percentage of pregnant women receiving first antenatal care (ANC) before 12 weeks of gestation during a visit to a districts (improve coverage of integrated RMNCAH -N services)
2.	Percentage of participating hospitals that have registered an increase in quality scores since last quarter (improve quality of essential RMNCAH-N services))
3.	Percentage of children 6-59 months with vitamin A supplementation participating districts (improve coverage child nutrition)
4.	Percentage of identified close contacts of confirmed COVID-19 cases followed up based on national guidelines (improve COVID-19 response)
5.	Percentage of health facilities managed under RBF contracts by the MOHCC Program Coordination Unit in participating rural districts (strengthen institutional capacity for performance based management)

D. Project Description

8. **The proposed fifth Additional Financing to the Health Sector Development Support Project (AF V) will continue to support the three current project components with some adjustments in scope and will introduce a COVID-19 emergency response component**. Support will include measures to improve coverage and quality, and strengthen implementation capacity to manage performance-based contracts, building on lessons learnt from implementation and assessments of RBF. Experiences of other countries and available evidence informed the design of the COVID-19 response component.

9. The following changes are proposed as part of AF V:

(i) Expand the PDO to support the COVID-19 emergency response while improving coverage and quality of essential RMNCAH-N interventions and institutional capacity for RBF contract management;
(ii) Include a new component, "Component 2: COVID-19 Emergency Response," with a cost of US$5 million;
(iii) Extend the AF IV grant implementation period from June 30, 2020 to September 30, 2020 and overall project implementation period to April 30, 2023;
(iv) Revise the Results Framework to reflect changes in the PDO, expanded project scope and implemenation period, as well as improve the measurement of results by rationalizing and reducing the number of outcome and intermediate outcome indicators;
(v) Adjust delivery of essential RMNCAH-N services and RBF approach to reduce infection risks from COVID-19;
(vi) Refocus RBF in provincial hospitals to be quality oriented and pilot (a) quality-focused RBF in central hospitals together with (b) community-mobilization RBF;
(vii) Scale-up the urban voucher scheme for poor pregnant women to more health facilities, include vitamin A supplementation for their 6-59 months old children and provide post exposure prophylaxis (PEP) for sexual, gender-based violence affected Urban Voucher (UV) program beneficiaries and their children;
(viii) Allow for simplified procurement procedures in accordance with the Bank Guidance: Procurement in Situations of Urgent need of Assistance or Capacity Constraints, dated March 7, 2019, and include Hands-on Extended Implementation Support and the option of using Bank Facilitated Procurement;
(ix) Strengthen Project Implementation Entity (PIE) staffing to reflect increased scope and activities; and
(x) Adjust the economic and technical analysis to reflect changes in Project scope and implementation period.

Component 1: Results-Based Financing in Delivery of Packages of Key Maternal, Child and Other Related Health Services (RMNCAH-N) [Total: US$36.35M; GOZ: US$27.9M and WB-GFF: US$8.45M]

This component will continue to support rural RBF in the 18 districts where RBF incentives are being financed by the GOZ. The GOZ will increase funding on an incremental basis to an additional 42 rural districts that are currently financed by the HDF. This component proposes to pilot and implement an Extended Supply Side Community (ESSC) RBF through community health workers to promote community participation as part of the overall rural RBF in four districts and pilot quality focused RBF in two central and four provincial hospitals; scale-up the UV scheme to 24 health facilities and expand its package to include vitamin A supplementation for 6-59 months old children of UV beneficiaries and PEP to poor urban pregnant women who are UV beneficiaries and their children who are affected by sexual and gender based violence.

Component 2. Management and Capacity Building [Total:US$10.5M; GOZ: US$1.3M and WB-GFF: US$9.2M]
This component will support overall program and project management and capacity building. This will include technical and operational support to (i) equip additional facilities participating in RBF (provincial and central hospitals, urban facilities); and (ii) design and implement some health financing reforms. It will also support the GOZ to (i) reconfigure

the RBF approach for essential RMNACH-N services to mitigate COVID-19-related risks and (ii) incorporate COVID response interventions. This component will continue to support RBF institutionalization and selected innovative approaches to the delivery of RMNCAH-N services at all levels of the health system, in line with the draft Zimbabwe HSIC, NHS towards Universal Health Coverage and the National COVID-19 Emergency Response Plan.

Finally, this component will finance project supervision including staff and consultants and incremental operating costs. It will also continue to support technical staff seconded to MOHCC Program Coordination Unit (PCU).

Component 3. Documentation, Monitoring and Verification of Results [Total: US$3.2M; GOZ: US$0.7M; WB-GFF: US$2.5M]

This component will support monitoring, evaluation, and external verification including the Health Professions Authority (HPA)[9] in performing its counter-verification role.

It also proposes to finance: (i) operational research in collaboration with the National Institute of Health Research (NIHR) to generate evidence and lessons from AF implementation[10] and (ii) joint review missions with other development partners as part of the Country Coordination Platform's [11] role in monitoring HSIC implementation.

In addition, this component will strengthen project-related mechanisms for grievance redress (GRM) and stakeholder engagement through provision of technical assistance (TA), equipment, and tools to improve current systems within the MOHCC and the PIE. It will also support documentation and dissemination of most significant changes and lessons.

Component 4. COVID-19 Response [WB-GFF: US$5M]

This component will provide immediate support to prevent COVID-19 from spreading and limit local transmission through containment strategies**.** It will prioritize infection prevention and control, contact tracing and surveillance. It will support enhancing disease detection capacities through provision of training for technical staff, laboratory equipment and systems to ensure prompt case finding and contact tracing, consistent with WHO guidelines. It will also enable the country to mobilize surge response capacity through trained and well-equipped frontline health workers and better equipped facilities. The component will also finance provisions for emergency response activities targeted at migrant and displaced populations in fragile, conflict or humanitarian emergency settings compounded by COVID-19.

[9] The Health Professions Authority of Zimbabwe (HPA) is responsible for registering health institutions and regulating services provided by these institutions.

[10] International consultants are envisioned to work with the newly established Health Systems Research Unit at NIHR in doing these evaluations in the process building their capacity in these types of research. This may involve training, co-investigation.

[11] Joint reviews by MOHCC, development partners, civil society organizations and private sector.

E. Implementation

Institutional and Implementation Arrangements

CORDAID will continue to serve as the PIE. It will handle all WB-GFF funds, remaining as the purchaser of services for the urban RBF and voucher program. It will expand its implementation responsibilities to cover provincial and central hospital quality-focused RBF pilots, Expanded Supply Side Community RBF pilot, and COVID-19 emergency response. The MOHCC PCU will continue to be the national purchaser for RBF services in the 18 rural districts being supported by the HSDSP. The Project will continue to engage civil society organizations and use third party verification (e.g. Health Professions Authority) to monitor RBF performance.

Regarding COVID-19 interventions, the PIE will work closely with the MOHCC-PCU which will, in turn, coordinate with the COVID-19 EOC at national and sub-national levels. The PIE will handle all fiduciary activities including procurement. While the National Pharmaceutical Company will handle storage and distribution of COVID response goods and equipment including those purchased through AF V, the PIE will monitor and verify that these items reach target facilities and are used for their intended purpose. To this end, it will use a geo-tracking system and pilot the use of block-chain technology. It will also mobilize Provincial Officers, as well as Health Center Committees which include community representatives from youth groups, women's associations, religious entities, etc. to confirm availability of equipment and supplies and service provision.

The Community Working Group on Health (network of community-based/civil organizations), international NGOs such as CORDAID and development partners also participate in the National RBF Steering Committee and several COVID-19 Response Committees. The Project Implementation Manual will be updated to clarify key stakeholders' (including relevant private sector entities) roles and responsibilities. Additional TA involving the WB Governance, Disaster Risk Management and HNP teams will be provided to improve coordination and governance of COVID 19 activities including strengthening public financial management. The project will also finance regular internal and external financial audits.

AF V proposes to finance the following additional technical staff: (i) a Maternal and Neonatal Health Technical Specialist, and a Reproductive, Adolescent and Family Planning Technical Specialist to support the MOHCC Family Health Department; (ii) a communications specialist to support RBF and COVID-19 response-related interventions; (iii) Operations Research Analyst, (iv) two regional health specialists to support provincial and central hospital RBF; (v) two community RBF officers; (vi) an additional UV Program Assistant, and (vii) an Environmental Safeguards Specialist. In addition, the PIE administrative staff shall be strengthened to include a (i) dedicated Accountant/Finance Officer; and (ii) a Procurement and Logistics Officer. Other positions such as safeguards staff to complement MOHCC staffing in implementing its COVID-19 response, Environmental and Social Management Framework (ESMF) and Infection Control and Waste Management Plan (ICWMP) will be confirmed during negotiations. Implementation arrangements will be extensively reviewed after two years.

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. Project activities will be scaled-up to operate in additional locations and the scope of interventions will widen. Urban RBF will include more health facilities. New project activities include, for example, the Expanded Supply Side Community RBF that will be piloted in four districts to support community mobilization activities and minor works related to water, sanitation and hygiene, as well as quality focused RBF that will be piloted in two central hospitals.

Several COVID interventions such as surveillance, monitoring, containment including PPE provision, and risk communication provision may be nationwide in scope. Potential negative impacts of the project are predictable, small-scale, and manageable provided that risk mitigation measures are adhered to. The project will exclude activities that may cause any permanent or temporary physical or economic displacement. Therefore, the Involuntary Resettlement Policy OP 4.12 is not triggered. AF V will fund new activities on COVID-19 emergency preparedness and response. While some social risks and impacts are significant, they are considered temporary, predictable, and readily managed through project design features and mitigation measures that consider sector capacity constraints. Specific locations or scope of these activities have not been identified but the project will primarily focus on installation of water tanks in selected isolation centers and basic sanitation facilities in critical areas. As was the case in AFs I to IV, no land acquisition or involuntary resettlement impacts are expected. All activities will be conducted within existing government facilities/grounds and no new land will be acquired or accessed.

G. Environmental and Social Safeguards Specialists on the Team

Ruma Tavorath, Environmental Specialist
Svetlana Khvostova, Environmental Specialist
Nicole Andrea Maywah, Environmental Specialist
Majbritt Fiil-Flynn, Social Specialist
Kudakwashe Dube, Social Specialist

SAFEGUARD POLICIES THAT MIGHT APPLY

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	The proposed AF will continue to support mostly activities that are aligned with the parent project and current AF. There will be some modifications based on lessons learnt during implementation and new activities on COVID-19 emergency preparedness and response. The project will cover more and new areas (with some possibly nationwide interventions) and include some new activities such as water and sanitation installation. The project will have positive impacts as it will improve COVID-19 surveillance, monitoring and containment. As was the case in AFs I to IV, no major civil works will be undertaken in AF V; only very minor

		sanitation structures (such as septic tanks or pit latrines, ventilated improved pit latrines, composting toilets or pit latrines with slabs), and the installation of water tanks in selected isolation centers, supplies for handwashing facilities and basic sanitation facilities in critical areas will be supported. These minor activities will be site-specific and will not have any significant environmental impacts on the ground. To assess and manage potential environmental and social risks and impacts, CORDAID will prepare an Environmental and Social Management Framework (ESMF) within 6 weeks of project effectiveness. While the national Health Care Waste Management Plan already in use will be updated to an Infection Control and Waste Management Plan (ICWMP) also within 6 weeks of effectiveness. Site-specific ESMPs or checklists will be prepared as needed during implementation. The ESMF and ICWMP will guide on the best practices for waste management and any other safeguards concern that may be identified including any necessary labor management measures. The ICWMP will present mitigation measures that consider the limited capacity level of the health sector.
Performance Standards for Private Sector Activities OP/BP 4.03	No	The AF will not finance any private sector activities
Natural Habitats OP/BP 4.04	No	The policy is not triggered as the AF will be restricted to already existing health facilities
Forests OP/BP 4.36	No	The AF will not involve any forests unless facilities are already located in a forest; any such activities will be identified in screening and appropriate measures taken as directed in the ESMF
Pest Management OP 4.09	No	The policy is not triggered as the AF will not finance the use of pesticides.
Physical Cultural Resources OP/BP 4.11	No	The project activities will only finance minor improvements for already existing structures which do not have PCR. The ESMF will include chance-find procedures as a precautionary measure.
Indigenous Peoples OP/BP 4.10	Yes	There is a possibility that indigenous communities could be present in or near several areas targeted by Component 4 (COVID response). If their presence is

		confirmed, the project will address any risks posed to them and measures put in place to ensure that they receive culturally appropriate benefits. This will be done through the specific targeting of stakeholder engagement activities relevant to Indigenous Peoples (IPs) that meet the requirements of OP4.10 and that a Social Assessment (SA) is carried out prior to any activities that would impact them. Following the SA, and as appropriate: (i) a stand-alone plan or framework may be developed; (ii) or key elements of risk mitigation and culturally appropriate benefits will be included in the ESMF. In case where indigenous communities will be affected by quarantine provisions or other targeted impacts, site-specific approaches will ensure adequate consideration of their specific cultural needs in accordance with OP 4.10, to the satisfaction of the Bank. Public consultations with representatives of indigenous communities and their organizations are provided for in the ESMF and will be further developed in subsequent IPPFs as appropriate considering their circumstances. IP organizations and representatives will be consulted during the preparation of the ESMF and IPPFs required as necessary.
Involuntary Resettlement OP/BP 4.12	No	No project activities require land acquisition or adversely impact livelihoods. Financing may support rehabilitation and minor upgrades at existing facilities.
Safety of Dams OP/BP 4.37	No	The AF will not involve the construction of dams.
Projects on International Waterways OP/BP 7.50	No	The AF will not involve international waterways.
Projects in Disputed Areas OP/BP 7.60	No	The AF will not involve disputed areas.

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 proposed AF will continue to support mostly activities that are aligned with the parent project with some

modifications based on implementation lessons and fund new activities including COVID-19 emergency preparedness and response. While some social risks and impacts are significant, they are considered temporary, predictable, and readily managed through project design features and mitigation measures. While the risks associated with COVID-19 and infectious medical waste are serious, with use of personal protective equipment and other behaviors outlined in WHO Guidelines, the risks are manageable and should not result in large-scale or significant impacts. The Infection Control and Waste Management Plan (ICWMP) will include risk mitigation measures that consider the health sector's capacity challenges. Therefore, the Parent Project classification as Category B will remain unchanged.

Environmental risks are primarily due to: (i) hazardous and medical waste (including infectious materials, liquid effluents, reagents, etc.) are expected to be generated from health facilities, hospitals, labs, quarantine, and screening posts. Improper handling, managing, transporting, and disposing of these waste streams pose occupational and community health and safety risks from COVID-19 and other infectious materials, radiological waste (from x-rays and the like) and other general waste; (ii) occupational health and safety, including accidental contact with infectious waste and the risk of COVID-19 spreading among health care workers. Poor practices during provision of medical services, blood testing, analysis of samples without proper protective equipment would pose a high risk of infection and possible mortality of healthcare workers; and (iii) installation of water tanks and basic sanitation and possible minor refurbishment. Therefore, effective administrative and infection-controls and engineering controls must be put in place to minimize these serious risks. Additionally, macroeconomic issues and low capacity in the health sector are also risks which will impact this project. The other environmental risks in the project issuing from the installation of water tanks and basic sanitation (including flush/pour flush to piped sewer system, septic tanks, pit latrines, ventilated improved pit latrines, composting toilets or pit latrines with slabs) are not significant and will not lead to any irreversible changes. These impacts will be managed with checklists or simple environmental and social management plans.

There are several key social risks including: (i) community health and safety, (ii) difficulties in access to services by vulnerable social groups (i.e. people with chronic conditions/disabled, poor people, migrants, the elderly and, disadvantaged sub-groups of women), (iii) misinformation in social media networks related to COVID-19 and stigma for those who will be quarantined or admitted to isolation or treatment centers, which may contribute to propagate contagion; (iv) issues resulting from people being kept in isolation, and (v) Gender Based Violence, in particular Sexual Exploitation and Abuse (GBV/SEA) risks may surge if restrictions on movement or quarantine measures are put in place. There are also increased risks of sexual exploitation and abuse associated with workers and outsiders who may be providing services to the community.

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 negative 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 potential environmental and social 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 and the potential adverse impacts due to the COVID-19 pandemic.

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.
The project will be implemented through the Catholic Organization for Relief and Development Aid (CORDAID) to leverage the well-established relationship with the Ministry of Health and Child Care (MOHCC), health implementation

in districts and their experience in working with implementation of World Bank projects since 2011. CORDAID has been instrumental in rolling out Zimbabwe's Public Healthcare Waste Management Regulations, introduced in 2011, that defines how key medical waste must be managed, transported and disposed.

The current World Bank project - Zimbabwe Health Sector Development Support Project AF IV (Parent project: P125229) - is being implemented under safeguard operational procedures. The current project has extensive measures in place to address environmental and social risks associated with infectious healthcare waste and community engagement measures. The project uses the 2011 National Health Care Waste Management Plan (HCWMP) for Zimbabwe as its environmental and social assessment and management plan.

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 will be administered on a quarterly basis, includes verification of medical waste measures by the facility. Indicators of medical waste handling will therefore be 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 payments. This will act as an incentive to health workers to adopt good waste management practices and ensure staff adheres to the guidelines.

The 2011 national HCWMP will be updated to an ICWMP that, among other items, will include specific guidelines to provide risk mitigation measures to prevent or minimize the spread of the infectious disease/COVID-19 to the community. The updated ICWMP will be prepared within 6 weeks of project effectiveness before any new project activities that generate medical waste are in place. The ICWMP will present mitigation measures that consider the health sector's limited capacity level.

To address the water and sanitation potential environmental and social risks and impacts, CORDAID will prepare an Environmental and Social Management Framework (ESMF) within 6 weeks of project effectiveness. The ESMF will clearly set out the environmental and social assessment requirements of the project's components and provide guidance on the preparation of site-specific ESMPs and/or checklists, and contractors' codes of conduct. CORDAID will commit to the provision of services and supplies to all people that are within the project's scope, regardless of their social status, based on urgency of the need, in line with the latest data related to the prevalence of COVID-19 cases in the ESMF.

Given Zimbabwe's urgent needs in the face of COVID-19, this AF will be processed under under paragraph 12(a): Projects in Situations of Urgent Need of Assistance or Capacity Constraints of Section III of the Bank's Investment Project Financing (IPF) Policy and paragraph 56: Exceptional Arrangements in Situations of Urgent Need of Assistance or Capacity Constraints which allows for environmental and social safeguards instruments to be prepared after project effectiveness. In any case, no project activities that require safeguards will take place on the ground without the necessary environmental and safeguards procedures instruments in place.

While protecting the health of communities from COVID-19 infection is a central part of the project, without adequate controls and procedures, project activities ranging from medical facility operation through to on-ground public engagement exercises have the potential to contribute to virus transmission and other community health and safety issues. Some project activities also present increased health and safety risks for project workers, particularly those working in medical and laboratory facilities. Clear communication of risks and prevention measures will be included in training and stakeholder engagement activities.

The project also directly supports measures to ensure that health care workers and the public at large does not pose a risk to others, through training and provision of PPE, as well as in terms of their social behaviors. To promote respectful workplaces, the project will continue to rely on the national Code of Ethics and the WHO Code of Ethics and Professional Conduct for healthcare workers and any potential engagement of community workers who may be engaged for contact tracing. The risks of Sexual Exploitation, Harassment, and Abuse will be assessed, and mitigation measures outlined in the ESMF. Similarly, any pertinent labor management issues will also be outlined and addressed in the ESMF. The new contracted workers will have orientation on and sign a code of conduct on expected behavior and safety standards including GBV/SEA risks.In case quarantine and isolation centers are to be protected by security personnel or they are involved in enforcement of government directives or containment of possible social unrest, it will be ensured that the security personnel follow strict rules of engagement and avoid any escalation of situation, including possible training/guidelines consistent with Bank guidance on the use of military or security personnel during public health emergencies “Use of military forces to assist in covid-19 operations”.

The parent project established a Grievance Redress Mechanism (GRM) based on both MOHCC conflict-resolution mechanisms as well as project-based steps to ensure that beneficiaries and all stakeholders have an opportunity and means to raise their concerns or provide suggestions regarding project-related activities. In addition, as part of the COVID-19 response, the MOHCC has established an Emergency Operations Centre (EOC) using a toll-free number for reporting suspected cases and grievances through provincial call centers. These mechanisms will integrate GBV-sensitive measures, including multiple channels to initiate a complaint and specific procedures for SEA, such as confidential and/or anonymous reporting with safe and ethical documenting of GBV and SEA cases. Finally, the project will link client satisfaction surveys with the GRM. Details of the GRM will be provided in the ESMF.

As an international NGO operating in the health care space, CORDAID is already on the forefront of COVID-19 responses. CORDAID, along with MOHCC, is therefore assessed to have the experience and capacity to carry out the necessary environmental and social due diligence aligned to the COVID-19 context. The current project's safeguards performance demonstrates this. In March 2016 an independent assessment reviewed implementation of the HCWMP under the ongoing project. The review found that the current project has led to the improvement of HCWM at both district hospitals and rural clinics. Through Results-Based Financing, the current project has been effective in financing the health institutions to enable the majority of participating facilities to meet the minimum standards prescribed. Of hospitals visited for the review, a large proportion were complying with the HCWM practices. The review found that a large proportion of the facilities that had no functional HCW infrastructure, now had at least the basic infrastructure to deliver health services in a relatively safe non-infectious environment than what was reported during the baseline rapid assessment that developed the HCWMP. An Environmental Specialist will now be added to the project team to ensure that the aforementioned ESMF and ICWMP are implemented in AF V.

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

Key stakeholders include: (i) health workers and (ii) communities served by health facilities contracted under the project. Health care waste plan was disclosed when the original project was approved in 2011

Though substantial efforts have been made through the parent project to ensure full participatory of key stakeholders during project preparation and implementation, AF V will ensure that information is meaningful, timely, and accessible to populations that are most at risk (such as women, youths, disabled persons and elderly people densely populated areas), and contribute to strengthening the capacities of community structures in promoting prevention messages in the community. Component 4's risk communication and community engagement activities are focused on

complementing efforts to ensure communication is strengthened in communities, enhancing provision of clear information related to risks and prevention measures. CORDAID in collaboration with MOHCC will facilitate appropriate stakeholder engagement and outreach towards differentiated audiences to ensure widespread sharing of project benefits as well as avoidance of potential rumors and social conflicts. Outreach and engagement measures will be constantly adjusted to accommodate changes in governments and international public health guidelines as the pandemic evolves. Adequate measures will be taken both to ensure that vulnerable groups have access to services and to prepare risk communications materials focusing on behavioral and socio-cultural risks and COVID-19 preventive measures using a variety of media, such as electronic media (internet,TV, radio), audiovisuals, toll-free call-in number, etc. These mechanisms for stakeholder engagement and public consultations will be outlined in the ESMF.

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

Environmental Assessment/Audit/Management Plan/Other

The review of this Safeguards has been Deferred.

Comments
Preparation and disclosure of the ESMF and ICWMP are deferred because of the emergency nature of the operation. Project is being processed under paragraph 12 of the WB IPF OP Section III Projects in Situations of Urgent Need or Capacity Constraints. The project has an already existing HCWMP that will be updated to the ICWMP. The ESMF and ICWMP will be prepared and disclosed within six weeks from Project effectiveness.

Indigenous Peoples Development Plan/Framework

The review of this Safeguards has been Deferred.

Comments
Preparation and disclosure of any IP related instrument (if necessary) is deferred because of the emergency nature of the operation. Project is being processed under paragraph 12 of the WB IPF OP Section III Projects in Situations of Urgent Need or Capacity Constraints.

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

OP/BP 4.10 - Indigenous Peoples

Has a separate Indigenous Peoples Plan/Planning Framework (as appropriate) been prepared in consultation with affected Indigenous Peoples?
No

The World Bank Policy on Disclosure of Information

Have relevant safeguard policies documents been sent to the World Bank for disclosure?
No
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?
No

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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