COMBINED PROJECT INFORMATION DOCUMENTS / INTEGRATED SAFEGUARDS DATA SHEET (PID/ISDS)

Additional Financing

Report No.: PIDISDSA21997

Date Prepared/Updated: 01-Jun-2017

I. BASIC INFORMATION

A. Basic Project Data

Country:	Zimbabwe	**Project ID:**	P163976
		Parent Project ID (if any):	P125229
Project Name:	Zimbabwe Health Sector Development Support Project III - AF (P163976)		
Parent Project Name:	Health Sector Development Support Project (P125229)		
Region:	AFRICA		
Estimated Appraisal Date:	24-May-2017	**Estimated Board Date:**	06-Jun-2017
Practice Area (Lead):	Health, Nutrition & Population	**Financing Instrument:**	Investment Project Financing
Borrower(s)	Ministry of Finance		
Implementing Agency	Stichting Cordaid		

Financing (in USD Million)

Financing Source	Amount
Borrower	5.00
Global Financing Facility	5.00
Financing Gap	0.00
Total Project Cost	10.00

Environmental Category:	B-Partial Assessment
Appraisal Review Decision (from Decision Note):	The review did authorize the team to appraise and negotiate
Other Decision:	
Is this a Repeater project?	No

B. Introduction and Context

Country Context

Zimbabwe is a landlocked country in southern Africa with an estimated population of 13 million, the

majority of whom live in rural areas (Census, 2012). Zimbabwe's economy depends heavily mining and agriculture. The country suffered a dramatic economic decline during the 1998-2008 period, which stimulated large-scale emigration of skilled workers and severely eroded the country's institutional capacity. Unsustainable fiscal deficits coupled with the emergence of hyperinflation in the early 2000s severely damaged Zimbabwe's economy . During this period, Zimbabwe's Gross Domestic Product (GDP) is estimated to have contracted by a third. An annual economic growth rate of 10% between 2010-2012 marked an improvement following the adoption of a multi-currency regime in early 2009 and the subsequent stabilization of prices. However, economic growth slowed after 2013 and fell behind the Sub-Saharan African average (World Bank 2015). In 2016, economic growth registered 0.7%, a decline from the already modest 1% gain of the previous year .

Zimbabwe's poverty trends lag behind those of other countries in the region, with poverty prevalence estimated at 63% and an estimated 16% of the population in extreme poverty (ZimVac 2014). Poverty is more widespread in rural households (76%) compared to the 38% in the urban areas. The number of poor households is anticipated to gradually increase by some 300,000 per year given the projected economic growth rates within the context of continued high population growth .

Zimbabwe's political economy has been characterized by efforts to address the economic challenges confounded by uncertainties and cycles of bust and booms linked to both droughts and political crises. Despite an improvement in the ranking score (from 47.33 to 48.17 out of 100), Zimbabwe's ranking declined from 153 to 155 out of 189 countries on the ease of doing business list. Government recurrent expenditure remains high—nearly 93% in 2016—leaving very little room for capital expenditure.

Sectoral and Institutional Context

Life expectancy in Zimbabwe is on par with the regional average and the country performs better than the Sub-Saharan Africa average for many health outcomes indicators. Zimbabwe's total fertility rate is relatively low by regional standards, but higher for adolescent girls. Mortality rate for infants and children under five is lower than the Sub-Saharan Africa average. High prevalence of tuberculosis (TB) and HIV/AIDS has taken a toll on Zimbabwe's health outcomes and health financing. The burden of communicable and maternal illness is matched by accelerated rates of non-communicable diseases (NCDs). In 2012, approximately 31% of total deaths in Zimbabwe were caused by NCDs, placing Zimbabwe at the Sub-Saharan African median. Negative lifestyle changes including unhealthy diets, physical inactivity, risky sexual behaviors (especially among youth) and smoking further complicate Zimbabwe's health profile. The burden of disease and health risks fall disproportionately on low-income peri-urban, urban and rural populations.

Despite commendable progress on some HIV/AIDS and malaria indicators, Zimbabwe was unable to meet key health-related Millennium Development Goals (MDGs) or its broad set of national health targets. MMR declined from 960 per 100,000 live births in 2010-2011 to 651 per 100,000 live births in 2015. Similarly, the under-five mortality rate dropped from 84 deaths per 1,000 live births in 2010/11 to 69 deaths per 1,000 live births in 2015. The infant mortality rate decreased from 57 deaths per 1,000 live births in 2010/11 to 50 deaths per 1,000 live births in 2015 (Zimstat 2016). However, such progress was in adequate for Zimbabwe to meet health-related MDGs target.

The poor's inability to pay for user fees at the point of care in both rural and urban areas, hampers access to basic health services in Zimbabwe. An estimated 7.6% of households in Zimbabwe incurred catastrophic health expenditure in 2015. The poorest suffered the most with 13.4% of poor households having catastrophic health expenditure vs. 2.8% of the richest. Direct user fees remain an important source of funding for district, mission, central and local government facilities, and most provinces with high incidence of poverty bear a disproportionately large burden of user fees. One strategy by the

Ministry of Health and Child Care (MOHCC) to provide equitable, quality and affordable health care is RBF. RBF in Zimbabwe is advancing the GOZ's efforts to improve equity in access to health services by: removing user fees; rebuilding quality of care standards; improving the referral system; strengthening decentralized service delivery; and revitalizing primary health care.
1.

C. Proposed Development Objective(s)

Original Project 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.

Current Project Development Objective(s) - Parent

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

Proposed Project Development Objective(s) - Additional Financing

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.

Key Results

(i) Percentage of birth attended by skilled health personnel in a health institution in participating rural districts
(ii) Percentage of women aged 15-49 years in participating rural districts receiving during their first or repeat visits one of the modern family planning methods
(iii) Percentage of partographs correctly filled
(iv) Percentage of health facilities implementing quality Improvement/Assurance model in participating rural districts

D. Project Description

The Health Sector Development Support (HSDS) Project, also known as the Results Based Financing (RBF) project, presently covers 4.1 million people out of a national population of 13.1 million. The government views the HSDS Project as an important instrument to: (i) increase demand and utilization of priority MCH services by poor households by removing financial barriers to accessing health services; (ii) strengthen performance of health facilities; and (iii) rebuild basic services that collapsed during the political and economic crises.

Given Zimbabwe's fragile state context, the HSDS Project has proven to be an effective mechanism for reaching poor populations with priority MCH services. The project enables financing to flow directly to front-line service providers while increasing accountability for performance and for financial resources by health providers in rural areas and low-income urban and peri-urban areas. In addition, the project directly strengthens health system planning and management capacity at decentralized levels. The HSDS Project has thus made key contributions to the wider Zimbabwe health system. These contributions are referenced in the Budget Strategy Papers and Budget Statements of the Ministry of Finance and Economic Development (MOFED) and include: Increased accountability for results and quality, particularly at health facilities and within their catchment area communities; Improved accuracy and timely reporting of health service delivery data by health facilities due to RBF

penalties and rewards; Increased health facility supervision by District Health Executives (DHEs) and Provincial Health Executives (PHEs), which the quarterly RBF grants enabled; Strengthened planning and utilization of resources at the health facility level through support provided by RBF for planning and prioritization of funding received; and enhanced community participation through health center committees (HCCs).

The impact evaluation of the parent project also demonstrated significant effects of the RBF mechanism on improving priority health outcomes. For example, the RBF intervention package increased the rate of deliveries attended by a skilled provider by 15 percentage points and of institutional deliveries by 13 percentage points compared with control districts. Among mothers with primary education or less, the intervention resulted in a 20 percentage point increase in deliveries attended by a skilled provider, greater than the increase for mothers with secondary or higher education. The intervention also appears to be mildly pro-poor, with a greater increase in skilled and facility deliveries to mothers in households with below median wealth. However, the rate of delivery by C-section increased more for mothers with above-median wealth in the intervention districts.

Component Name:
Delivery of Packages of Key Maternal, Child and Other Related Health Services
Comments (optional)
This component will support (i) the delivery of packages of basic health services in 18 targeted rural districts with a focus on MCH through results-based contracts with health service providers; (ii) supervision of such health services through results-based contracts with district, provincial and national health management teams; (iii) improvement in quality of care through the use of a revamped quality tool and the roll-out and evaluation of the Continuous Quality Improvement (CQI) model at the primary clinic level; and (iv) demand- and supply-side RBF for low-income urban families.

Component Name:
Management and Capacity Building in Results Based Financing
Comments (optional)
This component will support interventions to strengthen the capacity of health service providers and health supervisors to provide and oversee health services. Building on the progress so far, the Additional Financing will especially target: (i) governance and strategic RBF management capacity at national level, including the establishment of a “RBF purchasing” team; (ii) institutionalization of RBF and health financing; (iii) roll-out of CQI innovations to improve verification and supervision, including the use of portable electronic smart devices to enhance real-time feedback; and (iv) mentoring and peer learning among RBF stakeholders to learn from implementation.

Component Name:
Project Monitoring and Evaluation
Comments (optional)
This component will continue to support project supervision, monitoring, evaluation and external verification. In addition, the Additional Financing will support a process evaluation to examine cost-effective options for verifying results under RBF schemes. This builds on the pilot risk-based verification approach initiated under the second Additional Financing

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

The project implementation will take place in 8 provinces in Zimbabwe with a focus on rural health facilities as well as the two main cities, Harare and Bulawayo.

F. Environmental and Social Safeguards Specialists

Majbritt Fiil-Flynn(GSU07)

II. IMPLEMENTATION

Original project governance and implementation arrangements and stakeholders will continue to support RBF activities across all components. As under the original project, Cordaid will serve as the Project Implementing Entity (PIE). Cordaid will co-share technical positions with the Project Coordination Unit of the MOHCC that will be strengthened to implement RBF mechanism in the long term. The MOFED and MOHCC Policy, Planning and Monitoring and Evaluation Directorate, Finance and Administration Directorate and the Family Health Division will continue to play a lead role in project technical direction and management oversight. The core team of GOZ staff seconded to lead RBF will continue to work closely with Cordaid in operational, management and verification aspects of the project.

As a continuation of the existing arrangements under the Project, Cordaid will also serve as the fund-holder for urban health services and will contract: (i) the City Health Services Department for supervision of services, with DHEs under their jurisdiction; (ii) DHEs in urban areas for supervisory services of private and public facilities enrolled in the supply-side Additional Financing; (iii) public and screened private providers for achievement of quality standards based on an integrated supervision checklist; (iv) the MOLSS for enrollment of households and monitoring of demand-side component and households to ensure they receive benefits under the voucher scheme, and for consolidated reports on uptake of vouchers; and (v) CBOs for community-based client tracing and spot checks concerning quality of services received. The Additional Financing will support further streamlining of roles and responsibilities reflecting a maturing RBF project and mechanism; and strengthen multi-collaboration among three ministries and two municipalities. The MOLSS will coordinate client engagement, community monitoring and report to the PIE and the MOFED on voucher utilization by targeted households. The MOHCC will continue to play a regulatory role in setting standards of service provision and in both overall supervision and the supervision of Cordaid. The project's current counter-verification agency—the University of Zimbabwe College of Health Sciences—will expand its scope of services to include urban counter verification.

III. SAFEGUARD POLICIES THAT MIGHT APPLY

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	Project activities under the Additional Financing phase will remain the same as under the original project. No major civil works will be undertaken, only minor renovations (such as painting, plastering of walls, etc.). Minor works will follow national requirements. These are not expected to have any environmental impacts on the ground. However, improvement of the health services and improved access will be continued which will increase the quantity of health services and require management of increased amounts of infectious medical waste.

Natural Habitats OP/BP 4.04	No	The policy is not triggered as the project will be restricted to already existing health facilities and no ecologically sensitive habitats will be disturbed.
Forests OP/BP 4.36	No	The policy is not triggered as they project will not involve the loss of trees.
Pest Management OP 4.09	No	The policy is not triggered as the project will not finance the use of pesticides
Physical Cultural Resources OP/BP 4.11	No	The policy is not triggered as the project will not involve any earth works that will result in chance finds. All minor civil and renovation works will be restricted to already existing structures.
Indigenous Peoples OP/BP 4.10	No	The additional finance for the project will continue implementation in eight provinces in Zimbabwe with a focus on rural health facilities as well as the two main cities, Harare and Bulawayo. The policy is not triggered as there are no indigenous people in the project locations as defined by Bank policy.
Involuntary Resettlement OP/BP 4.12	No	There are no activities under the project that would require land acquisition or adversely impact livelihoods. There is no new construction under the project, but financing may support minor works on already existing rural health centers
Safety of Dams OP/BP 4.37	No	The policy is not triggered as it will not involve the construction of dams.
Projects on International Waterways OP/BP 7.50	No	The policy is not triggered as it will not be implemented on any international waterways.
Projects in Disputed Areas OP/BP 7.60	No	The policy is not triggered as it will not be implemented in any disputed area.

IV. Key Safeguard Policy Issues and Their Management

A. Summary of Key Safeguard Issues

1. Describe any safeguard issues and impacts associated with the proposed project. Identify and describe any potential large scale, significant and/or irreversible impacts:
The investments to be supported by the AF are similar to those that are already being financed under the Parent Project, and therefore the AF will maintain the Environmental Category B classification of the Parent Project. Implementation of health care waste management has been largely satisfactory.
2. Describe any potential indirect and/or long term impacts due to anticipated future activities in the project area:
The sub-projects to be supported under the AF will not generate indirect and/or long-term

impacts envisaged in the project areas.
3. Describe any project alternatives (if relevant) considered to help avoid or minimize adverse impacts.
The alternative to avoid the environmental impact is a no project alternative, which is not acceptable in view of the high morbidity and mortality rates of women and children in the country.
4. Describe measures taken by the borrower to address safeguard policy issues. Provide an assessment of borrower capacity to plan and implement the measures described.
During the project preparation of the Parent Project, the Borrower has prepared a Health Care Waste 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 borrower has experience in supporting Bank funded projects and has an existing health care waste management plan.
5. Identify the key stakeholders and describe the mechanisms for consultation and disclosure on safeguard policies, with an emphasis on potentially affected people.
The Health Care Waste Management Plan (HCWMP) was prepared using a broad-based public consultation approach, involving stakeholder groups in the health sector and NGOs, private sector institutions and local communities within the country at the different levels. The HCWMP report was publicly disclosed in-country in April 2011 through series of workshops.

B. Disclosure Requirements

Environmental Assessment/Audit/Management Plan/Other	
Date of receipt by the Bank	18-Apr-2011
Date of submission to InfoShop	26-May-2011
For category A projects, date of distributing the Executive Summary of the EA to the Executive Directors	
"In country" Disclosure	
If the project triggers the Pest Management and/or Physical Cultural Resources policies, the respective issues are to be addressed and disclosed as part of the Environmental Assessment/Audit/or EMP.	
If in-country disclosure of any of the above documents is not expected, please explain why::	

C. Compliance Monitoring Indicators at the Corporate Level

OP/BP/GP 4.01 - Environment Assessment						
Does the project require a stand-alone EA (including EMP) report?	Yes	[]	No	[X]	NA	[]
If yes, then did the Regional Environment Unit or Practice Manager (PM) review and approve the EA report?	Yes	[]	No	[]	NA	[X]
Are the cost and the accountabilities for the EMP incorporated in the credit/loan?	Yes	[]	No	[]	NA	[X]
The World Bank Policy on Disclosure of Information						
Have relevant safeguard policies documents been sent to the World Bank's Infoshop?	Yes	[]	No	[]	NA	[X]
Have relevant documents been disclosed in-country in a public place in a form and language that are understandable and accessible to project-affected groups and local NGOs?	Yes	[]	No	[]	NA	[X]
All Safeguard Policies						
Have satisfactory calendar, budget and clear institutional responsibilities been prepared for the implementation of measures related to safeguard policies?	Yes	[]	No	[]	NA	[X]
Have costs related to safeguard policy measures been included in the project cost?	Yes	[]	No	[]	NA	[X]
Does the Monitoring and Evaluation system of the project include the monitoring of safeguard impacts and measures related to safeguard policies?	Yes	[]	No	[]	NA	[X]
Have satisfactory implementation arrangements been agreed with the borrower and the same been adequately reflected in the project legal documents?	Yes	[]	No	[]	NA	[X]

V. Contact point

World Bank

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VII. Approval

Task Team Leader(s):	Name:Ronald Upenyu Mutasa	
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Safeguards Advisor:	Name: Nathalie S. Munzberg (SA)	Date: 01-Jun-2017
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