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

Report No.: PIDISDSA15541

Date Prepared/Updated: 12-Nov-2015

I. BASIC INFORMATION

A. Basic Project Data

Country:	Zimbabwe	**Project ID:**	P156879
		Parent Project ID (if any):	P125229
Project Name:	Zimbabwe Health Sector Development Support Project AF II (P156879)		
Parent Project Name:	Health Sector Development Support Project (P125229)		
Region:	AFRICA		
Estimated Appraisal Date:	30-Oct-2015	**Estimated Board Date:**	20-Nov-2015
Practice Area (Lead):	Health, Nutrition & Population	**Lending Instrument:**	Investment Project Financing
Sector(s):	Health (70%), Public administration- Health (30%)		
Theme(s):	Health system performance (40%), Population and reproductive health (40%), Participation and civic engagement (20%)		
Borrower(s):	Ministry of Finance		
Implementing Agency:	Stichting Cordaid		

Financing (in USD Million)

Financing Source	Amount
Borrower	5.00
Health Results-based Financing	10.00
Financing Gap	0.00
Total Project Cost	15.00

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	No

Repeater project?	

B. Introduction and Context

Country Context

In 2000, Zimbabwe's well-organized public service delivery system fell into steady decline toward near-collapse in 2008. In eight years Gross Domestic Product (GDP) fell by more than 35 percent and per capita health expenditure plummeted. For a four-year period following 2009, macro-economic stabilization improved government funding for social service delivery and development partner financing increased. This period of rapid recovery resulted in an average annual GDP growth of 10 percent between 2010 and 2012. However, in 2013 GDP growth slowed and fell behind the sub-Saharan African average (World Bank 2015).

Zimbabwe's poverty trends lag behind those of other countries in the region. One assessment of ten select urban areas reveals a Total Consumption Line Poverty rate of 70 percent (ZimVac 2012), and the corresponding figure is presumably higher in rural areas—where the majority of Zimbabwe's 13 million people live.

Sectoral and institutional Context

The combined effects of the HIV/AIDS epidemic, which peaked in 1998, and the socio-economic crises of 2000-2008 unraveled decades of impressive human development achievements. Prior to 2001, Zimbabwe had one of the best health systems in sub-Saharan Africa. Reliable, functional infrastructure down to the village level ensured that through the late 1990s approximately 85 percent of Zimbabweans lived within 10 km of a health facility.

Zimbabwe will not achieve many health-related 2015 MDG targets. At least 70 percent of annual deaths in Zimbabwe are attributable to communicable, maternal, perinatal and nutritional illness, and a rapidly growing burden of non-communicable diseases (NCDs) poses new threats. The maternal mortality ratio (MMR) declined from 960 deaths per 100,000 births (ZDHS 2010/11) to 614 deaths per 100,000 births in 2014. The current rate remains unacceptably high in part because the 80 percent rate of institutional deliveries implies that a fifth of pregnant women still deliver at home (MDG 5). Infant mortality increased from 51 deaths per 1,000 live births in 1990 to 55 in 2014 (MDG 5). Under-five mortality increased from 76 per 1,000 live births in 1990 to 84 in 2010-11 and decreased to 75 in 2014 . The unmet need for family planning among married women aged 15-49 was 10.4 percent (MDG 5).

Service coverage improved between 2009 and 2014, but lower quality of care and inequities in service utilization continue to disproportionately affect poor populations. With the 2009 economic recovery, social sector ministries managed to restore and maintain basic service delivery. However, the decline in government funding has transferred the financial burden onto patients in the form of user fees that obstruct poor people's access to health services. Although government policy is to provide free basic services—in particular maternal and child health services—many health institutions continue to collect user fees to partially cover their operational costs. While all population segments in Zimbabwe forgo healthcare due to financial constraints, poorer people typically rely on lower-quality low-level facilities while richer people are more likely to use provincial or central hospitals and private services.

Household out-of-pocket spending represented the largest share of all financing sources in 2010.

Household out-of-pocket spending increased from 36 percent in 2001 to 39 percent of total health expenditures in (2010 National Health Accounts). Less than 10 percent of the population has health insurance, of which employer-based health insurance accounts for 50 percent. Thus, most of the population, especially those not formally employed, remains vulnerable to financial shock from healthcare expenditures.

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.

Key Results

Select Key Results

(i) Percentage of births 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, contributes to the implementation of government health policies by: (i) increasing poor households' demand for and utilization of priority maternal and child health (MCH) services by removing user-fees for select high impact MCH services; and (ii) operationalizing the Government of Zimbabwe's Results-Based Management Strategy. The project will now have an additional emphasis on strengthening the performance of health facilities including through continuous quality improvement (CQI).

The project supports the contracting of health facilities for the delivery of a specified package of essential MCH services. Facilities are paid on a fee-for-service basis based on quantity and quality of service delivery achieved in a given period. At the district level, hospitals receive performance based contracts to improve the quality of emergency obstetric newborn and pediatric care. District Health Executives (DHEs) are contracted to assess and support quality of care improvements during supervision of health centers. Remote facilities receive higher payments than non-remote ones for the delivery of the package of services. For all facilities in the scheme, an internal and external verification process audits the reported data on quality of services. Quarterly audits verify the quality of services provided based on a standard protocol that reflects prioritized quality of care measures.

The project is being implemented in 18 of 63 rural districts and two low-income urban pilot districts in the two largest cities. The project presently covers 4.1 million of Zimbabwe's 13.1 million population. Project results so far are encouraging: an impact evaluation has demonstrated significant effects of the RBF mechanism on improving priority health outcomes. While the entire country witnessed increases in coverage of services based on the MICS 2014 report, the rate of increase in RBF districts was faster. For example, RBF plus elimination of user fees increased the share of deliveries attended by a skilled provider by 15 percentage points and deliveries taking place in a facility by 13 percentage points in RBF districts compared to control districts.

Component Name

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

Comments (optional)

a) Supply-side RBF in 18 rural districts: supporting the delivery of packages of basic health services under results based service delivery contracts; supervision of such services to improve clinical quality of care; and introduction of CQI; and
b) Demand and supply-side RBF targeted at low-income urban districts to: protect the urban poor from the financial burden of MCH services; improve qualit

Component Name

Component 2: Management and Capacity Building in Results Based Financing

Comments (optional)

This component currently supports interventions to strengthen the capacity of health service providers and health supervisors to provide and oversee health services through the provision of: (i) basic medical equipment and other related goods; and (ii) training and technical assistance to the Ministry of Health and Child Care (MOHCC), the Ministry of Finance and Economic Development (MOFED), and t

Component Name

Component 3: Project Monitoring and Evaluation

Comments (optional)

This component supports project supervision, monitoring, documentation, reporting, evaluation and external verification. It finances development of mechanisms for the MOHCC in rural districts and City Health Services Departments to monitor the project's effect on equity. The Additional Financing will strengthen data management deficiencies observed within the MOHCC and the Project Implementing En

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

Ruma Tavorath (GENDR)

II. Implementation

Institutional and Implementation Arrangements

The MOFED and MOHCC will continue to both lead the project's technical direction and provide management oversight. Original project governance, implementation arrangements and stakeholders will remain in place with Cordaid serving as the PIE. A priority of the Additional Financing is to support the GOZ to finalize a medium-term strategic vision of RBF as part of the broader national health financing strategy. The PIE will therefore maintain its additional mandate to build government capacity in RBF. The PIE will also continue to serve as the fund-holder for urban health services and will manage contracts.

III. Safeguard Policies that might apply

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	
Natural Habitats OP/BP 4.04	No	
Forests OP/BP 4.36	No	
Pest Management OP 4.09	No	
Physical Cultural Resources OP/BP 4.11	No	
Indigenous Peoples OP/BP 4.10	No	
Involuntary Resettlement OP/ BP 4.12	No	
Safety of Dams OP/BP 4.37	No	
Projects on International Waterways OP/BP 7.50	No	
Projects in Disputed Areas OP/ BP 7.60	No	

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:
None. This is category B project and 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:
None.
3. Describe any project alternatives (if relevant) considered to help avoid or minimize adverse impacts.
None. The project actually strengthens adherence to best practices in the management of health care waste from health facilities.
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.
Borrower 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.
Key stakeholders include: (i) health workers and (ii) communities served by health facilities contracted under the project. Health care waste plan was discolosed when the original project was approved in 2011.

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	
Comments:	
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 [ ] NA [ ]
If yes, then did the Regional Environment Unit or Practice Manager (PM) review and approve the EA report?	Yes [×] No [ ] NA [ ]
Are the cost and the accountabilities for the EMP incorporated in the credit/loan?	Yes [×] No [ ] NA [ ]
The World Bank Policy on Disclosure of Information	
Have relevant safeguard policies documents been sent to the World Bank's Infoshop?	Yes [×] No [ ] NA [ ]
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 [ ]
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 [ ]
Have costs related to safeguard policy measures been included in the project cost?	Yes [×] No [ ] NA [ ]
Does the Monitoring and Evaluation system of the project	Yes [×] No [ ] NA [ ]

include the monitoring of safeguard impacts and measures related to safeguard policies?	
Have satisfactory implementation arrangements been agreed with the borrower and the same been adequately reflected in the project legal documents?	Yes [×] No [ ] NA [ ]

V. Contact point

World Bank

Contact: Ronald Upenyu Mutasa
Title: Senior Health Specialist

Borrower/Client/Recipient

Name: Ministry of Finance
Contact: Mr. Willard L. Manungo
Title: Permanent Secretary
Email: wlmanungo@yahoo.com

Implementing Agencies

Name: Stichting Cordaid
Contact: Ms Filippine
Title: PIE
Email: info@cordaid.net

VI. For more information contact:

The InfoShop
The World Bank
1818 H Street, NW
Washington, D.C. 20433
Telephone: (202) 458-4500
Fax: (202) 522-1500
Web: http://www.worldbank.org/infoshop

VII. Approval

Task Team Leader(s):	Name: Ronald Upenyu Mutasa	
Approved By		
Practice Manager/ Manager:	Name:	Date:
Country Director:	Name: Camille Anne Nuamah (CD)	Date: 13-Nov-2015