



Project Information Document (PID)

Appraisal Stage | Date Prepared/Updated: 09-Apr-2020 | Report No: PIDA29093

**BASIC INFORMATION****A. Basic Project Data**

Country Eswatini	Project ID P173883	Project Name Eswatini COVID-19 Emergency Response Project	Parent Project ID (if any)
Region AFRICA	Estimated Appraisal Date 01-Apr-2020	Estimated Board Date 09-Apr-2020	Practice Area (Lead) Health, Nutrition & Population
Financing Instrument Investment Project Financing	Borrower(s) Sizakele Dlamini	Implementing Agency Dr. Simon Zwane	

Proposed Development Objective(s)

The Program Development Objective is to prevent, detect and respond to the threat posed by COVID-19 and strengthen national systems for public health preparedness in Eswatini.

Components

Component 1: Emergency COVID-19 Response and Evaluation

Component 2: Implementation Management and Monitoring and Evaluation

PROJECT FINANCING DATA (US\$, Millions)**SUMMARY**

Total Project Cost	6.00
Total Financing	6.00
of which IBRD/IDA	6.00
Financing Gap	0.00

DETAILS**World Bank Group Financing**

International Bank for Reconstruction and Development (IBRD)	6.00
--	------

Environmental and Social Risk Classification



Substantial

Decision

Other Decision (as needed)



B. Introduction and Context

Program Context

1. An outbreak of the coronavirus disease (COVID-19) caused by the 2019 novel coronavirus (SARS-CoV-2) has been spreading rapidly across the world since December 2019, following the diagnosis of the initial cases in Wuhan, Hubei Province, China. Since the beginning of March 2020, the number of cases outside China has increased thirteenfold and the number of affected countries has tripled. On March 11, 2020, the World Health Organization (WHO) declared a global pandemic as the coronavirus rapidly spreads across the world. As of March 25, 2020, the outbreak has resulted in an estimated 450,307 cases and 20,664 deaths in 199 countries.

2. COVID-19 is one of several emerging infectious diseases (EID) outbreaks in recent decades that have emerged from animals in contact with humans, resulting in major outbreaks with significant public health and economic impacts. The last moderately severe influenza pandemics were in 1957 and 1968; each killed more than a million people around the world. Although countries are now far more prepared than in the past, the world is also far more interconnected, and many more people today have behavior risk factors such as tobacco use¹ and pre-existing chronic health problems that make viral respiratory infections particularly dangerous². With COVID-19, scientists are still trying to understand the full picture of the disease symptoms and severity. Reported symptoms in patients have varied from mild to severe, and can include fever, cough and shortness of breath. In general, studies of hospitalized patients have found that about 83% to 98% of patients develop a fever, 76% to 82% develop a dry cough and 11% to 44% develop fatigue or muscle aches³. Other symptoms, including headache, sore throat, abdominal pain, and diarrhea, have been reported, but are less common. While 3.7% of the people worldwide confirmed as having been infected have died, WHO has been careful not to describe that as a mortality rate or death rate. This is because in an unfolding epidemic it can be misleading to look simply at the estimate of deaths divided by cases so far. Hence, given that the actual prevalence of COVID-19 infection remains unknown in most countries, it poses unparalleled challenges with respect to global containment and mitigation. These issues reinforce the need to strengthen the response to COVID-19 across all IDA/IBRD countries to minimize the global risk and impact posed by this disease.

3. This project is prepared under the global framework of the World Bank COVID-19 Response financed under the Fast Track COVID-19 Facility (FCTF).

Country Context

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

5. Macroeconomic performance has been hampered by severe droughts due to climate change and growing fiscal challenges emanating from rapid growth in the public wage bill combined with volatile Southern African Customs

¹ Marquez, PV. 2020. "Does Tobacco Smoking Increases the Risk of Coronavirus Disease (Covid-19) Severity? The Case of China."

<http://www.pvmarquez.com/Covid-19>

² Fauci, AS, Lane, C, and Redfield, RR. 2020. "Covid-19 — Navigating the Uncharted." New Eng J of Medicine, DOI: 10.1056/NEJMe2002387

³ Del Rio, C. and Malani, PN. 2020. "COVID-19—New Insights on a Rapidly Changing Epidemic." JAMA, doi:10.1001/jama.2020.3072



Union transfers. GDP growth rate was 2.4% in 2018. The 2019 contraction caused a high fiscal deficit and cash flow challenges. In 2019, the International Monetary Fund (IMF) urged Eswatini to undertake expenditure rationalization to stabilize debt dynamics and rebalance its recurrent spending, particularly wage spending. With the Government's focus on reducing the structural and fiscal imbalances, until very recently, the 2020-21 budget had depicted a positive outlook with a growth recovery up to 2.9% in 2020.

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

7. On March 17, 2020, Eswatini declared a State of Emergency. The primary crisis is one of health. The fundamental concern is to contain the disease and delay the spread of infection. The secondary crisis that Eswatini is facing is the economic impact of the outbreak. While the actions currently being undertaken to try to contain the outbreak will have lasting economic costs, the GOE recognizes that the cost of not acting would be far greater. The Government has put in place several measures to assist individuals and businesses to cope with the consequences of the crisis.⁴ These includes the passing of a budget by Parliament to support the COVID-19 response and activation of the National Disaster Management Agency to coordinate the response. Development partners and donors including the United States' President's Emergency Plan for HIV/AIDS Relief (PEPFAR), United Nations agencies, and the Global Fund to Fight AIDS, Tuberculosis, and Malaria have also committed funds to support the COVID-19 response amounting to approximately US\$2.9 million.

8. Although classified as a lower middle-income country (GNI per capita US\$2,960), high poverty rates and income inequality (Gini coefficient of 49.3) challenge Eswatini's economic and human development potential. If a prolonged crisis leads to higher inflation and potential labor market impacts, these may have knock-on effects on vulnerable households. While the national poverty rate has fallen in recent years (from 63% in 2010 to 59% in 2017), it remains very high, particularly in rural areas (70%) and in two regions (Lubombo (72%) and Shiselweni (67%). Eswatini's hunger levels are "serious"; almost two thirds of the population are food insecure with detrimental impact on pregnant women and children. For vulnerable populations and the poor, the economic impact of the outbreak can deepen poverty and trigger potential intergenerational effects.

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

10. Recognizing the importance of human capital as a central contributor to sustainable economic growth and poverty reduction, in March 2019 Eswatini joined the group of early adopters of the Human Capital Project (HCP). Despite its lower middle-income status, Eswatini's Human Capital Index (HCI) - a composite measure of survival of under-five children, educational attainment, and adult survival rate and stunting - is low, on par with the Sub-Saharan average and lower-income countries. An HCI score of 0.41 indicates that a child born today in Eswatini will only be

⁴ Ministry of Finance Press Statement: Measures to be taken following the national emergency declaration



41% as productive when they grow up as they could be if they benefited from complete education and full health. Investing in human capital would increase the GDP per worker. To meet Eswatini's vision for human development, about a 15-percentage point increase is required from its current HCI score, calling for improvements in health, nutrition and education services and cross-sectoral synergies. As this rapidly spreading outbreak can undermine Eswatini's human capital ambition, investments to boost the country's emergency preparedness and response to COVID-19 are critical.

Sectoral and Institutional Context

13. Despite the GOE's commitment to strengthen pandemic preparedness and response, capacity is limited. Eswatini is a signatory to the 2005 International Health Regulations (IHR). A 2018 Joint External Evaluation (JEE) of Eswatini's IHR core capacities⁵ identified a number of technical areas where capacity strengthening was required, including *inter alia* in preparedness, emergency response operations, risk communication, workforce development, reporting, and medical countermeasures and personnel deployment in times of emergency.

14. Eswatini faces significant risks regarding the potential impact of the COVID-19 pandemic. As of March 25, there are five confirmed cases of COVID-19 in Eswatini – all with recent travel history. The risk of local transmission and further imported cases, particularly from South Africa, is very high. The latter has reported 709 cases in the same time period. Due to the close economic linkages, there is significant human movement between Eswatini and South Africa. In South Africa the number of confirmed COVID-19 cases has been increasing at an exponential rate, which has implication on the ability of Eswatini to contain the spread of infection. In the absence of vigorous response measures, there is a high potential for the number of COVID-19 cases in Eswatini to rise significantly, and the country's health care system is currently not able to cope with substantial numbers of COVID-19 cases. Eswatini currently has 11 hospitals and five health centers that provide secondary care, providing an average of 2.1 hospital beds per 1000 population (compared to an average of 2.4 and 4.1 beds per 1000 population in low- and middle-income countries and high-income countries respectively). Only two hospitals have an intensive care unit (ICU) - Mbabane Government Hospital (MGH), the national referral hospital, and Raleigh Fitkin Memorial Hospital (RFMH), a mission hospital – providing a total of 14 ICU beds. Due to ICU demand from non-COVID-19 cases at MGH, the GOE has decided to increase ICU bed capacity in RFMH and introduce ICU services in the Lubombo referral hospital. Mathematical modeling⁶ suggests that even under a 'suppressed' epidemic scenario, Eswatini will require up to 113 critical care beds for COVID-19 alone.

15. The GOE has taken swift action to respond to the unfolding COVID-19 emergency. Upon declaration of the state of emergency on 17 March 2020, the GOE announced several measures to help curtail the spread of COVID-19 including the closure of schools and tertiary institutions, suspending large public and private gatherings (of more than 50 people) and non-essential international travel for its citizens, and restricting hospital visitations, among other measures. A partial lockdown came into effect on 27 March 2020, with stricter measures imposed including limiting movement of citizens to essential activities, restricting public gatherings to no more than 20 people, and restricting border movement to goods and cargo and returning citizens and residents (who must comply with a 14-day mandatory quarantine) as well as other measures. The army and the police have been mobilized to ensure adherence to the measures and the Government is fast tracking regulations that will enforce "stiff penalties on would be defaulters".

⁵Joint external evaluation of IHR core capacities of the Kingdom of Eswatini. Geneva: World Health Organization; 2018 (WHO/WHE/CPI/2018.27). Licence: CC BY-NC-SA 3.0 IGO.

⁶Imperial College. 26 March 2020. Report 12: The Global Impact of COVID-19 and Strategies for Mitigation and Suppression



16. Eswatini has developed a National Contingency Plan to address COVID-19. The plan's general objectives are to: (i) Effectively provide all the relevant technical expertise to strengthen COVID-2019 Preparedness and Response and enhance the implementation of the International Health Regulations (2005) through resilient public health systems; (ii) Support capacity building of health workers at all levels in public health surveillance, outbreak investigation and response to COVID-2019 and other public health emergencies; (iii) Improve diagnostic capacity through supply of laboratory consumables and supplies for a proper referral of samples; (iv) Enhance risk communication, and community engagement; (v) Enhance COVID-2019 event management at points of entry, entry screening for COVID-2019 at airports and ground crossings, as well as exit screening in case of introduction of an COVID-2019 case; and (vi) Comprehensively monitor the coverage, quality and impact of preparedness, response and systems building activities. The Plan includes three response levels (alert, serious and emergency, with Eswatini currently in the emergency phase) and activities are defined for the country to follow under nine strategic axes⁷, in alignment with WHO's Strategic Preparedness and Response Plan for COVID-19. The Government has requested financial and technical support from partners for implementation of key activities under this plan.

17. The Government relies on various inter- and intra-ministerial coordination mechanisms that will help support this project. In accordance with the provisions of the IHR of 2005, coordination, communication and advocacy related to the IHR in Eswatini are implemented in the context of Integrated Disease Surveillance and Response (IDSR). Following a One Health approach, it brings together Ministries of Health, Agriculture and Environmental Services as well as nongovernmental organizations (NGOs) and the private sector. Eswatini has a fully staffed IHR National Focal Point (NFP) Secretariat that operates continuously and reports to WHO within 24 hours as prescribed in the IHR. The National Epidemic Task Force provides leadership to the Epidemic Task Force (ETF) and rapid response team (RRT) structures and collaborates with and provides coordination for multiple Ministry of Health (MOH) units, external agencies and NGOs involved in a large-scale response. The country also has an operational National Disaster Management Agency (NDMA) that provides coordination across relevant sectors and actors to implement a response to emergencies, including public health emergencies of international concern (PHEIC) and pandemics. To implement the COVID-19 Emergency Plan the Government has also established various emergency coordination structures including a Cabinet sub-committee, an Emergency Task Force, and Regional and Sector Committees.

18. In addition to the threat of COVID-19, Eswatini's large HIV epidemic, persistently high maternal and child mortality, increasing non-communicable diseases (NCDs) and malnutrition affect its human capital formation. While this project will support Eswatini to prevent, detect and respond to the threat posed by COVID-19, the Health System Strengthening for Human Capital Development in Eswatini project (P168564) will ramp up investments in reproductive, maternal, neonatal, child and adolescent health (RMNCAH) services as well as nutrition and non-communicable diseases, across the continuum of care. The focus on strengthened primary health care will alleviate pressure on the secondary and tertiary level of care that are critical to respond to the most severe COVID-19 cases.

19. The project is aligned with World Bank Group strategic priorities, particularly the WBG's mission to end extreme poverty and boost shared prosperity. The Program is focused on preparedness which is also critical to achieving Universal Health Coverage.

⁷ (1) Coordination; (2) Surveillance, (3) rapid response teams, and (3) case investigation; (4) Laboratory support; (5) Case Management; (6) Infection Prevention and Control; (7) Port health; (8) Risk Communication and Community Engagement; (9) Operational support and logistics



20. **Lastly, the project is aligned with the World Bank’s country-level strategy⁸ for support to Eswatini.** This operation, together with the other World Bank-supported lending operations,⁹ will assist the GOE beyond the emergency response to the pandemic; they will strengthen systems and address the medium- to longer term requirements of prevention and preparedness.

Proposed Development Objective(s)

Development Objective(s) (From PAD)

21. The Project Development Objective is to prevent, detect and respond to the threat posed by COVID-19 and strengthen national systems for public health preparedness in Eswatini.

Results

- Percentage of suspected cases reported that are tested according to national guidelines¹⁰
- Percentage of confirmed COVID-19 cases managed as per national protocol
- Number of public hospitals with COVID-19 triage capacity
- Number of individuals reached with tailored information

⁸ World Bank 2018. The Performance and Learning Review (PLR – Report No. 126205-SZ) extended the Country Partnership Strategy (CPS) by two years to FY2020.

⁹ Health System Strengthening for Human Capital Development (P168564), Network Reinforcement and Access Project (P166170); Water Supply and Sanitation Access Project (P166697); Basic Education and Skills Project (P173151)

¹⁰ Numerator: number of COVID-19 cases reported and investigated according to national guidelines. Denominator: Total number of suspected COVID-19 cases reported.



D. Project Description

22. The project components are aligned with the objectives of the COVID-19 SPRP and comprise 2 components: (1) Emergency COVID-19 Response; and (2) Implementation Management and Monitoring and Evaluation. The components aim to strengthen Eswatini's health system preparedness to respond to the COVID-19 emergency and potential future emergencies. The components will include climate-change adaptation measures and will address gender issues, as necessary. The proposed project will be financed by an IBRD loan of US\$6 million, using an Investment Project Financing (IPF) instrument under the multiphase programmatic approach (MPA), over a two-year period.

Component 1: Emergency COVID-19 Response

23. This component will provide support to Eswatini to minimize the risk of further imported cases and limit local transmission through containment strategies. It will support the implementation of Eswatini's COVID-19 National Contingency Plan in close coordination and with strong support from UN agencies and other partners. This component supports: (i) strengthening COVID-19 case detection, confirmation, case tracing, recording and reporting; (ii) health systems strengthening for COVID-19 preparedness planning; and (iii) improving the implementation of social distancing measures and strengthening communication preparedness.

(1) Strengthen COVID-19 case detection, confirmation, contact tracing, recording, and reporting

24. The project will provide technical assistance and procure goods and equipment to (i) strengthen disease surveillance systems and the in-country testing capacity through scale up of rapid near patient molecular testing and other testing technology – including engaging the private sector – as appropriate and strengthening of health facilities and the National Reference Laboratory (NRL) (and other public health laboratories as deemed necessary) in specimen collection, packaging, storage, shipment and epidemiological capacity for early detection and confirmation of cases; (ii) combine detection of new cases with active contact tracing; (iii) support epidemiological investigation; (iv) strengthen risk assessment; (v) strengthen screening, isolation and follow up of travelers at point of entry; and (vi) provide on-time data and information for guiding decision-making and response and mitigation activities.

(2) Health System Strengthening for COVID-19 Preparedness Planning

25. Technical and financial assistance will be provided to the health care system for preparedness planning to provide optimal medical care, maintain essential community services and to minimize risks for patients and health personnel, including training health facilities' staff and front-line workers on risk mitigation measures and providing them with the appropriate protective equipment, as well as with water supply, sanitation and hygiene materials, and health care waste management services.¹¹ Strengthened clinical care capacity will be achieved through financing plans for establishing specialized units in selected hospitals, treatment guidelines, clinical training of health workers and hospital infection control guidelines. Local containment will be supported through the establishment of local isolation units in hospitals. Widespread infection control training and measures will also be instituted across health facilities and ambulances. As COVID-19 would place a substantial burden on inpatient and outpatient health care services, support would be provided for temporary surge capacity for service delivery, reorganizing and repurposing/equipping the Lubombo referral hospital and the RFM hospital to increase ICU capacity, as well as other selected sites as deemed necessary, for the delivery of critical medical services and to cope with increased demand of services posed by the outbreak, develop intra-hospital infection control measures, and procure ambulances fully equipped for highly infectious diseases.

(3) Improve implementation of social distancing measures and strengthen communication preparedness

26. An effective measure to prevent contracting a respiratory virus such as COVID-19 is to limit, as much as possible, contact with the public. Therefore, the project will provide technical assistance to support improvements in the



implementation of ‘social distancing measures’ already in place in country by developing a well-designed communication strategy targeting parents, traditional and religious leaders and the general public, guidelines for the management of at risk groups such as guidelines for elderly isolation and pension pick-up, and guidelines for alternative drug pick-up for people living with HIV and other chronic conditions. It is important to clarify that the Bank will not support the enforcement of social distancing measures when they involve actions by the police or the military, or otherwise that require the use of force. The project will also provide technical and financial assistance for behavior change communication activities that will support cost-effective and sustainable methods such as promotion of handwashing, food hygiene, and safe water practices through various communication channels via mass media, counseling, schools, workplace, and integrated into specific interventions as well as ongoing outreach activities of ministries and sectors, especially ministries of health, education, agriculture, and transport. In coordination with other development partners, complementary support will be provided for information and two-way communication activities to raise awareness, knowledge and understanding among the general population about the risk and potential impact of the pandemic. Community mobilization will take place through trained community health workers (Rural Health Motivators and Community Volunteers), religious leaders and traditional healers. In addition, support will be provided for: (i) the development and distribution of basic communication materials (such as question and answer sheets and fact sheets in Siswati on COVID-19, and (ii) general preventive measures such as “dos” and “don’ts” for the general public; (iii) information and guidelines for health care providers: (iv) training modules (web-based, printed, and video); (v) presentations, slide sets, videos, and documentaries; and (vi) symposia on surveillance, treatment and prophylaxis.

Component 2: Implementation Management and Monitoring and Evaluation

27. **Project Management.** Support for the strengthening of public structures for the coordination and management of the project will be provided, including central and local (decentralized) arrangements for coordination of activities, financial management and procurement. The MOH’s implementation team will be strengthened through capacity building and recruitment of consultants responsible for overall administration, procurement, and financial management of the project. To this end, the project will support costs associated with project coordination.

28. **Monitoring and Evaluation (M&E).** This component will support the monitoring and evaluation of prevention and preparedness, building capacity for clinical and public health research, and joint-learning across and within countries. This component will support training in participatory monitoring and evaluation at all administrative levels, evaluation workshops, and development of an action plan for M&E and replication of successful models.

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

¹¹ Support for water supply, sanitation and hygiene is within existing health care facilities and not expected to include any major greenfield civil works. Activities include support for provision of hand washing stations and bulk water supply from existing commercially operating vendors with no water supply expected from new sources. As these activities are small scale, they will not have an impact on international waterways.



E. Implementation

Institutional and Implementation Arrangements

31. The design of the proposed implementation arrangement is informed by lessons from a health sector project that closed in 2018 (P110156) and a recent assessment of the MOH's implementation capacity for critical functions, undertaken for a pipeline project, currently at appraisal stage (P168564).
32. **Cabinet-level Intersectoral Coordination and Steering.** Cabinet-level intersectoral coordination and steering oversight will be provided by the National Emergency Management Committee (NEMC, Cabinet sub-committee), chaired by the Deputy Prime Minister. To support the NEMC, the National Emergency Task Team (NETT) was formed, which is comprised of members of different sectors, and representation from the National Disaster Management Agency (NDMA). The NETT is tasked to implement the National and Regional Emergency Plans and Procedures and coordinate the preparedness and response activities.
33. **Implementation Level.** As the primary crisis is health, the lead technical agency for project implementation will be the Ministry of Health (MOH). To ensure robust technical oversight and agility, the following two bodies will support project implementation:
- **The MOH Senior Management Team (SMT), chaired by the Principal Secretary, provides overall strategic implementation of the COVID-19 sector response.** They are responsible for providing the necessary resources, strategic guidance and facilitating the feedback loop between the Cabinet-level intersectoral coordination and steering committee and the National Public Health Emergency Committee (NPHEMC) tasked with the technical response for the sector. The NPHEMC is chaired by the MOH (Senior Medical Officer, Public Health Lead). The committee is comprised of MOH technical leads and experts critical for response to public health emergencies and representatives from Development Partners (UN agencies and the World Bank). To support regional preparedness and response, the NPHEMC has regional response committees that are chaired by the emergency response and preparedness officers in each region and comprise of regional nurse managers and designated allied workers responsible for the evacuations, isolation of patients and contact tracing. The regional chairpersons are members of the regional health management teams thus provide feedback to the regional health administrators on the response while being members of the NPHEMC.
 - **Core Implementation Team.** An agile implementation team will be established to support project effectiveness. The core team is to be comprised primarily of MOH staff (civil servants). The implementation team will be led by a Coordinator. For effective and timely decision making the Coordinator will report to the Principle Secretary of the MOH, who serves as a member of the NETT. With oversight by the Coordinator, the implementation team will be comprised of specialists for fiduciary controls (Financial Management and Procurement), monitoring and evaluation, and environmental and social risk management. For critical functions where the MOH technical capacity or knowledge of World Bank procedures and standards is limited, the project will provide surge capacity for a specified duration through specialist consultants. For operational efficiency, it is proposed that some technical roles (fiduciary, E&S) are shared between this emergency project implementation team and the PIU proposed for the health sector project under preparation (P168564). Sharing technical staff is expected to reduce overhead costs across the two projects, and by tapping into retractive financing, it can provide surge capacity early on to accelerate effectiveness. The Coordinators for the two projects (P173883 and P168564) will ensure that the PIU responsibilities are organized in a way to harness operational benefits and reduce operating costs.



CONTACT POINT

World Bank

Thulani Clement Matsebula
Sr Economist (Health)

Edit V. Velenyi
Senior Economist

Borrower/Client/Recipient

Sizakele Dlamini
Ms. Sizakele Dlamini
Principal Secretary, Ministry of Finance
dlamini@gmail.com

Implementing Agencies

Dr. Simon Zwane
Simon Dr. Zwane
Principal Secretary, Ministry of Health
smz1157@gmail.com

FOR MORE INFORMATION CONTACT

The World Bank
1818 H Street, NW
Washington, D.C. 20433
Telephone: (202) 473-1000
Web: <http://www.worldbank.org/projects>

APPROVAL

Task Team Leader(s):	Thulani Clement Matsebula Edit V. Velenyi
----------------------	--

Approved By

Environmental and Social Standards Advisor:		
---	--	--



Practice Manager/Manager:		
Country Director:	Asmeen Khan	10-Apr-2020
