



Project Information Document (PID)

Appraisal Stage | Date Prepared/Updated: 12-Aug-2021 | Report No: PIDA32160



BASIC INFORMATION

A. Basic Project Data

Country Zimbabwe	Project ID P176141	Project Name Zimbabwe COVID-19 Emergency Response Project	Parent Project ID (if any)
Region AFRICA EAST	Estimated Appraisal Date 01-Jun-2021	Estimated Board Date 31-Aug-2021	Practice Area (Lead) Health, Nutrition & Population
Financing Instrument Investment Project Financing	Borrower(s) Republic of Zimbabwe	Implementing Agency CORDAID	

Proposed Development Objective(s)

To support the Government of Zimbabwe to deploy and manage COVID-19 vaccines and strengthen related health system capacity.

Components

Vaccine Deployment and Related Risk Communication and Community Engagement
Climate Friendly Related Health System Strengthening
Overall Response Coordination and Project Management, Monitoring and Evaluation

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

Yes

PROJECT FINANCING DATA (US\$, Millions)

SUMMARY

Total Project Cost	6.58
Total Financing	6.58
of which IBRD/IDA	0.00
Financing Gap	0.00

DETAILS

Non-World Bank Group Financing



Trust Funds	6.58
Energy Sector Management Assistance Program	1.58
Health Emergency Preparedness and Response Multi-Donor Trust	5.00

Environmental and Social Risk Classification

Substantial

Decision

The review did authorize the team to appraise and negotiate

Other Decision (as needed)

This is the pre-appraisal Project Information Document.

B. Introduction and Context

Country Context

1. **Zimbabwe is a landlocked¹ and lower-middle-income² country with a gross national income per capita of US\$1,390 (Atlas method, 2019 from WDI 2020) and a population of 14.86 million (UN data based on Census 2012 data).** Zimbabwe has a population density of 33 persons per square kilometer. Its population is young: 41 percent are below 15 years old while four percent are aged 65 years and above. Women account for 52 percent of the total population. Approximately 67 percent of the population live in rural areas.

2. **Due to climate shocks and challenges in implementing certain reforms, Zimbabwe dealt with economic and humanitarian challenges prior to the COVID-19 pandemic.** The prolonged drought from 2019 to 2020, together with Cyclone Idai - the worst cyclone in the country's history - have strained its economy. While the government made progress in implementing fiscal reforms and reducing fiscal deficits, its expansionary monetary policy further elevated prices during the first half of 2020 when prices increased at double-digit rates per month. While subsequent fiscal and monetary stabilization efforts slowed inflation to single-digit monthly increases, 2020's annual average inflation of 550 percent was more than double 2019's inflation rate. The COVID-19 pandemic exacerbated inflation and labor and commodity shortages.³

3. **Measures taken by the GOZ since 2020 to mitigate the impact of COVID-19 and resulting lockdowns eventually contributed toward stabilizing the economy, although further improvements would significantly depend on how the pandemic and global economic situation evolve.** Inflation in

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.

³ World Bank. 2021. Zimbabwe Economic Update.



Zimbabwe peaked in 2020, reaching more than 550 percent but has since declined to an annual inflation rate of 161.9 percent in May 2021.⁴ The exchange rate also stabilized over the same period. Real Gross Domestic Product (GDP) is projected to rebound from reductions in 2019 and 2020, while the 2021 budget's proportional allocation to the health sector has significantly increased.⁵ However, risks remain because of a possible prolonged pandemic and weaker global demand, limiting economic growth and human capital investments and increasing poverty.

Sectoral and Institutional Context

4. **Prior to the COVID-19 pandemic, Zimbabwe's progress in improving health outcomes and expenditure efficiency has been mixed.** Zimbabwe's human capital index (HCI)⁶ increased from 0.41 in 2010 to 0.47 in 2020. Its HCI index is higher than the Sub-Saharan African 2020 average (0.20) but is slightly lower than the average (0.48) for lower-middle income countries.⁷ Zimbabwe's Maternal Mortality Ratio, a key indicator of the nation's health system status, decreased from 651 in 2015 (ZDHS) to 462 maternal deaths per 100,000 live births (MICS 2019) but remains high and ranks lower compared to its regional peers. Under-five mortality also decreased but remains high at 78 per 1,000 live births (MICS 2019). HIV and tuberculosis (TB) prevalence has also declined. While underweight in under-five children increased from 8.4 percent in 2015 (Demographic Health Survey/DHS 2015) to 9.7 percent in 2019, stunting in under-five children decreased from 26.8 percent in 2015 (DHS) to 23.5 percent in 2019 (Multiple Indicator Cluster Survey/MICS 2019). However, neonatal mortality has remained at 32 per 1,000 live births since 2009 (MICS 2019). Government Health Expenditures (GHE) increased from US\$523 million in 2015 to US\$963 million in 2018 but declined to US\$301 million in 2019 and US\$222 million in 2020. In addition, GHE as a share of GDP decreased from 2.6 percent in 2015 to 1.9 percent in 2019; provisional data from the Ministry of Finance and Economic Development's (MOFED) 2021-2023 Macroeconomic Fiscal Framework suggests it may have fallen to 1.1 percent in 2020 although this would need to be interpreted with caution.⁸ The draft Health Public Expenditure Review (WB 2021) notes that the major reduction in GHE in absolute terms in 2019 resulted mainly from inflation as opposed to a de-prioritization of the health sector. In view of its overall tight fiscal space, Zimbabwe could undertake certain measures to improve efficiency of its current health spending such as strengthening monitoring and evaluation (M&E) and internal audits, reducing fragmentation including aligning different Government plans for human resources in health management, and establishing transparent resource allocation criteria.

5. **The COVID-19 outbreak further undermined gains made in service delivery that had started to decline around mid-2019 due to inflation and climatic shocks.** As mentioned in the preceding section, economic and climatic shocks, and Cyclone Idai contributed to increasing inflation and foreign currency shortages. In the second half of 2019, due to the eroded value of their salaries, over 500 junior doctors went on strike for nearly five months, and nurses reduced their working hours. The government increased

⁴ National Consumer Price Index 2021.

⁵ World Bank. Health Public Expenditure Review 2021 based on MOFED data

⁶ 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.

⁷ WB Zimbabwe HCI Brief 2020

⁸ Caution should be taken in interpreting provisional and incomplete spending data for 2020. In addition, MOFED clarified that the nature of the pandemic entailed that an important share of health spending was managed outside of the MOHCC during 2020. For example, the Ministry of Local Government managed COVID isolation centers and upgrading of health facilities in 2020.



its health sector budget by at least 40 percent, adjusted salaries twice, provided additional allowances, and offered housing and vehicle loans in 2019, but these efforts were insufficient to cushion the impact of inflation rates that reached 522 percent by the end 2019. The COVID-19 pandemic further affected service delivery due to the national lockdowns and related social distancing restrictions to minimize the risk of COVID-19 transmission. While results-based financing in the health sector helped cushion inflation's impact, the decrease in real value of salaries and reported personal protective equipment shortages led to doctors and nurses' strikes and/or absences starting in May/June 2020. Although the majority of health workers returned to work after September 2020 after the Government committed to implement a stabilization plan, there are reports of facilities operating with fewer staff while some facilities remained closed, particularly in urban areas. The mini-Poverty, Income, Consumption and Expenditure Surveys (PICES) conducted in 2019 and 2020 show a decrease in rural dwellers who sought treatment from 81 percent to 71 percent although more urban dwellers sought treatment (77 percent to 83 percent). In addition, the share of persons not seeking treatment due to lack of funds increased in both rural (from 62 percent to 90 percent) and urban (from 70 percent to 93 percent) areas. Data from a sample of health facilities indicate reductions in several reproductive, maternal, and child health and nutrition services (e.g., antenatal care, postnatal care, institutional deliveries, family planning and growth monitoring) and indicators (e.g., institutional maternal deaths and home deliveries) that worsened since 2018 in selected health facilities (WB 2021).

6. **Compared to several countries in the region and despite its socio-economic challenges, Zimbabwe has reported less than originally anticipated COVID-19 cases, although it has experienced two case surges and a third surge is underway since cases have significantly risen since June 2021.** Since March 20, 2020, when Zimbabwe reported its first COVID-19 case, cumulative cases have increased to 117,954 with 93,502 recoveries and 3,991 deaths by August 12, 2021. In contrast, Zimbabwe's neighbouring country, South Africa, has reported the highest case load in Africa, with cumulative cases reaching 2,554,240 cases and 75,774 deaths as of August 12, 2021. Zimbabwe has experienced three waves characterized by a surge in cases. The first wave reached a peak of 490 cases per day on August 1, 2020, and the second wave, which started in early December 2020, reached a peak of 1,365 cases per day on January 5, 2021. Until June 2021, metropolitan provinces have been the major hotspots of the pandemic, with Bulawayo and Harare accounting for the highest shares of COVID-19 cases. At present, Zimbabwe is experiencing a surge in cases (third wave) that began in June 2021 which is continuing with 41,573 cases and 1659 deaths in the last 28 days as of August 12, 2021⁹. New confirmed COVID-19 cases increased from 226 during the week of May 29 to June 4, 2021 to 11,824 during the week of July 24 to 30, 2021 and then declined to 7,955 during the week of August 1 to 6, 2021. Similarly, COVID-related deaths spiked from 12 during the week of May 29 to June 4, 2021 to 529 during the week of July 24 to 30, 2021 and then declined to 315 during the week of August 1 to 6, 2021. Due to the still high number of COVID cases and related deaths, the Government extended the national lockdown which has been in effect since July 6, 2021 to at least August 22, 2021. Almost all provinces have experienced this surge. As of August 6, 2021, Harare accounted for the highest share of COVID-19 cases (22.1 percent), followed by Mashonaland West Province (13.4 percent) and then Bulawayo (10.4 percent).¹⁰ During the pandemic's initial phase, most of the reported cases were imported, however, more than 98 percent of COVID-19 positive cases in Zimbabwe are now attributed to local transmission. Males account for 51 percent of the COVID cases and

⁹ COVID-19 Dashboard by the Center for Systems Science and Engineering at Johns Hopkins University [https://gisanddata.maps.arcgis.com/apps/dashboards/bda7594740fd40299423467b48e9ecf6]

¹⁰ MOHCC and WHO. COVID Weekly Situation Reports.



57 percent of COVID-related deaths¹¹.

7. **Zimbabwe is implementing its Intersectoral COVID-19 Response Plan and Vaccine Deployment Plan.** The Government initiated COVID-19 vaccinations on February 22, 2021. As of August 12, 2021, a total of 1,933,260 persons in Zimbabwe have received their first COVID-19 vaccine dose, while 1,084,392 people received their second dose for a total of 3,017,652 vaccine doses provided. Except for South Africa, Zimbabwe has a much higher number of fully vaccinated individuals compared to many countries in the region including its three other neighboring countries: Botswana, Mozambique, and Zambia.¹²

C. Proposed Development Objective(s)

8. To support the Government of Zimbabwe to deploy and manage COVID-19 vaccines and strengthen related health system capacity.

Key Results

9. Proposed indicators are as follows:
- Percentage of population vaccinated, which is included in the priority population as defined in the national plan, disaggregated by gender
 - Proportion of primary health care facilities with functional solar-powered cold chain system (solar direct drive refrigerators)

D. Project Description

10. **The proposed project will be implemented over 18 months, complementing activities being/to be supported under the HSDSP AF V.** These activities were selected based on lessons in the IAR 2020, Zimbabwe's response to the surge in cases during the second wave from December 2020 to March 2021, and lessons learned from implementation of the National Vaccine Deployment Plan since February 2021. As the situation in Zimbabwe evolves and/or as new evidence emerges regarding the pandemic, the proposed activities below will be further fine-tuned and prioritized. Table 1 summarizes project financing by components and sources of funding.

11. **The proposed project's design considers that the broader goal of reducing the incidence of moderate to severe cases of COVID-19 and related mortality could be achieved by investing in activities that have the combined effect of accelerating vaccination coverage while minimizing risks of spread among unvaccinated groups and addressing operational inefficiencies.** In view of this overall approach, the project will support vaccine deployment activities including outreach, equipment, training and contribute toward the implementation of a functional system to routinely track equitable vaccination coverage and actively monitor adverse events. These activities will be complemented by interventions that strengthen the capacity for routine modeling and genomic sequencing analysis to provide timely information on hotspots and groups to be targeted for vaccination. In addition, the project will finance activities that increase community level knowledge on vaccination benefits vis-a-vis risks though

¹¹ MOHCC-WHO Weekly Report. August 7, 2021.

¹² The number of persons who have received complete doses in Botswana, Malawi, Mozambique, and Zambia: 132,117; 190,017; 478,487; and 153,597, respectively. Among Zimbabwe's neighboring countries, only South Africa has a higher number of fully vaccinated individuals (3,719,508) as of August 12, 2021 (WHO website)



strengthened communication and community engagement while also enhancing the capacity of health workers to implement appropriate infection prevention and control measures. The project will also support the implementation of a systemic institutional approach that is responsive to client concerns/grievances. It will also strengthen sector governance, for example, by expanding the implementation of a transparent tracking system for COVID-19 response commodities.

Component 1. Vaccine Deployment and Related Risk Communication and Community Engagement
(HEPRTF: US\$3.52 million)

12. This component will support deployment of vaccines that meet WB Vaccine Acceptance Criteria (VAC). At present, Zimbabwe is using two vaccines that meet WB VAC: Sinopharm and Sinovac. The country expects to avail this year of WHO EUL vaccines from the African Union and COVAX Facility. The MCAZ recently approved J&J for emergency use authorization.

13. **Sub-component 1.a Vaccine Deployment.** This sub-component will contribute toward strengthening the public health system's capacity to deploy vaccines through capacity building, eligible allowances, goods, and equipment. It will also monitor whether deployment is proceeding according to the NDVP and strengthen vaccine related waste management transportation systems. Activities to be funded include:

- a. Outreach and vaccine distribution including fuel, repair, and maintenance service of vehicles used for vaccine distribution
- b. Supervision and monitoring of vaccine deployment including ensuring implementation of the NDVP. Special attention will be given to women, people with disabilities, and others among targeted groups who may face particular barriers to access information and services. Supportive supervision and visits will be facilitated by strategic use of Information, Communication, and Technology (ICT), and include procurement of electronic data capturing tools for health facilities. The project will also support the set up and implementation of Impilo COVID-19 Vaccination Authentication. This is an Electronic Health Record mobile application solution that will enable a QR code to be assigned to every COVID-19 vaccination certificate.¹³ This application captures personal information including patient health status, contact address while also keeping information secure.
- c. Vaccine efficacy monitoring/checks, as well as TA to the MOHCC to revise, update, and implement the safety monitoring plan to enable swift detection of any AEFI
- d. Procurement of PPE for public COVID-19 vaccination centers and capacity building for rational use of PPE, including the development of guidance tools and training through physical and virtual methods
- e. Vaccine waste management training and logistics such as transport of wastes related to vaccine deployment for off-site incineration, and M&E

14. **Sub-component 1.2 Risk Communication and Community Engagement.** This sub-component will also finance TA, eligible allowances, equipment, and supplies to support risk communication and engagement at the community level to complement NDVP implementation:

¹³ The GoZ and MOHCC, in collaboration with the Harare Institute of Technology, developed this solution for the production of authentic and secure COVID-19 vaccination certificates.



- a. Development and facilitation of community-led responses to increase uptake of public health measures including COVID-19 vaccination. This will include interpersonal communication at community level through door-to-door and street-level awareness campaigns, use public-address vehicles;¹⁴ as well as community feedback mechanisms at local level such as the use of registers or rumor logbooks and suggestion boxes, Grievance Redress Mechanisms (GRMs), seconding Health Promotion Officers (HPOs) to EOCs, as well as ensuring community feedback is transmitted to high level meetings
- b. Research, monitoring, evaluation, and documentation of all RCCE activities at all levels, through community dialogues, trainings of community influencers, political leaders, school health teams and community, sensitization meetings, development of IEC materials on COVID-19 and vaccination, dissemination of messages through radio, TV, social media, and bulk short SMS
- c. Psychosocial support systems for both healthcare workers and general population by building capacity of community health workers, and national psychosocial center
- d. Community discussion forums with local and traditional leaders and school heads to share information about gender-based violence (GBV), sexual exploitation, abuse and harassment (SEA-H) and GRM. Priority will be given to the Tshwa and Doma districts which tend to be the most vulnerable and often forgotten areas.

Component 2. Climate Friendly Related Health System Strengthening (ESMAP: US\$1.575 million)

15. **This component will support complementary strategic activities to facilitate the implementation of the COVID-19 NDVP, focusing on climate friendly health system strengthening activities that support vaccine deployment.** It will finance capacity building, goods, climate-friendly cold chain equipment including cold boxes and solar direct drive refrigerators; transport including refrigerated trucks; and installation and maintenance of solar energy in health facilities.

Component 3. Overall Response Coordination and Project Management, Monitoring & Evaluation (HEPRTF: US\$1.48 million)

16. Under this component, the HEPRTF will support:
- a. Coordination using a results-based financing (RBF) approach¹⁵ of National and Provincial Level EOCs, vehicle maintenance and fuel for key National Response Pillar leads to coordinate and monitor COVID-19 response activities, and eligible administrative¹⁶ costs
 - b. Response coordination, monitoring, and evaluation activities through the MOHCC M&E department including assisting MOHCC in expanding the commodity tracking system¹⁷ for pharmaceuticals, PPE, test kits, etc.; as well as audits, reviews, and other activities to ensure governance and accountability.

¹⁵ The HEPRTF will complement efforts to strengthen the national EOC which is currently being supported through the WB HSDSP AFV and by WHO. It will also support decentralization of the EOCs to the provinces. Both national and provincial level EOCs will use an RBF approach.

¹⁶ Government salaries are not eligible for financing under the HEPRTF.

¹⁷ The country is already deploying electronic health records (EHR) and the EHR includes a pharmacy module. The EHR system is already developing the additional features for last mile tracking with support from HSDSP AF V. The HEPRTF would complement budget gaps such as training and procurement of gadgets.



- c. Capacity building in the following areas: mathematical modeling capacity of the COVID-19 response surveillance and coordination pillars; genomic sequencing at the National Microbiology Reference Laboratory (NMRL) including procurement of a genomic sequencing machine and reagents; and training and orientation of health staff (Data Managers, Health Information Officers) on Go-data and data management in COVID-19
- d. Environmental and social instruments validation, dissemination, and capacity building of stakeholders at various levels

Table 1. Project Financing by Component and Funding Source

Project Components	HEPRTF	ESMAP	Total Funding
	US\$ million	US\$ million	US\$ million
Component 1. Vaccine Deployment and Related Risk Communication and Community Engagement Sub-component 1.a Vaccine Deployment Sub-component 1.b Risk Communication and Community Engagement	3.42	-	3.42
Component 2. Climate Friendly Related Health System Strengthening	-	1.575	1.575
Component 3. Overall Coordination and Project Administration, Monitoring & Evaluation	1.48	-	1.48
Grand Total	5.0	1.575	6.575

Note: The HERP Grant will finance all activities except Component 2 which will be financed by the ESMAP Grant. Both grants will have separate disbursement categories.

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

17. **Environmental risks are substantial.** Support to COVID-19 vaccine deployment and related health system strengthening will have considerable positive outcomes as it aims to prevent, detect and respond to the threat posed by COVID-19 and strengthen national systems for public health preparedness. However, the COVID-19 vaccination activities can also have potential adverse environmental, health and safety (EHS) risks if an appropriate system for collection, transportation and disposal of medical wastes is not put place. It is important to note that while the project will support the deployment of WB-eligible vaccines, it will not directly purchase or administer the vaccines. The project is only financing the enabling



environment and infrastructure for vaccine delivery and other measures to address COVID-19 pandemic. Vaccination programs or vaccines are not entirely without risk as adverse reactions /adverse events following immunization might sometimes occur following vaccination which may be due to the vaccine or by an error in the administration or handling of the vaccines. Hence, the project will contribute to an appropriate COVID-19 vaccines safety monitoring system to respond to adverse events following immunization (AEFI) cases, if any. Taking into consideration the uniqueness and complexity of the vaccine safety monitoring of COVID-19 vaccine, the client's capacity to identify, report, investigate, and analyze adverse events following immunization and determine the cause of and respond to safety issues should be given due attention. Furthermore, an appropriate cold chain system should be in place so as to maintain the potency of the vaccines and the quality of the immunization service. Immunization programs also entail safe injection practices so that potential risks to the patients, healthcare personnel, and others could be avoided or minimized as unsafe injection practices that can result in disease transmission. The implementing agency should therefore establish and maintain an appropriate EHS risk management system for monitoring and surveillance of AEFIs; safe injections; for proper collection, transportation, and disposal of hazardous medical wastes; and for minimization of occupational health and safety risks. Despite the client's considerable capacity to manage the EHS risks associated with the activities, given the enormity of the COVID-19 challenge (its infectiousness, mortality, pandemic nature, etc.), the new vaccines and Zimbabwe's macroeconomic situation, environmental risk of the AF is therefore rated as substantial at this stage. The small works associated with installation of solar equipment will be in existing primary health care facilities are expected to have minor environmental impact.

18. **Social risks are substantial.** The key social risks related to this operation is are; (i) marginalized and vulnerable social groups being unable to access vaccines , facilities, and services designed to combat the disease; (ii) social conflict resulting from the limited availability of vaccines and social tensions related to the difficulties of a pandemic situation; (iii) GBV/SEA-H risks among patients and health care providers, especially in relation to distribution of lifesaving vaccines; (iv) inappropriate data protection measures and insufficient/not effective stakeholder communication on the vaccine roll-out strategy and information about vaccines that could result in rumors about the effects of vaccines on one's health and concerns about the efficacy of vaccines that are being used in-country, contributing to vaccine hesitancy even among health workers; and (v) risks associated with AEFI. Based on these findings, the social risk rating of this project is Substantial.

19. **Sexual Exploitation and Abuse/Sexual Harassment (SEA/SH) Risk Rating isModerate.** Gender-based violence and/or sexual exploitation, abuse and harassment (GBV/SEA-H), risk is Moderate based on the nature and scale of activities, and existing analysis of the country context on GBV. To manage and mitigate GBV/SEA-H, the project shall (i) prepare, adopt, and implement a GBV/SEA-H Action Plan (as part of the ESMF); (ii) ensure that the codes of conduct and GBV/SEA-H prevention provisions are integrated into all contractual and contracting documents (ToRs, tender documents, and workers' contracts); and (iii) ensure all staff are trained on SEA-H risks and sign the codes of conduct before starting work on any project activities.

20. **Six World Bank Environmental and Social Framework (ESF) Environmental and Social Standards (ESSs) are relevant for the Project.** These are: ESS1 Assessment and Management of Environmental and Social Risks and Impacts; ESS2 Labor and Working Conditions; ESS3 Resource Efficiency and Pollution Prevention and Management; ESS4 Community Health and Safety; ESS7 Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities and ESS10 Stakeholder Engagement and



Information Disclosure. In addition to the ESS, the Environmental, Health and Safety Guidelines (EHSG) also apply to this project especially the General and Health Care Facilities EHSGs. A Draft Environmental and Social Commitment Plan (ESCP) has been agreed with the Government, which sets out actions required for managing environmental and social risks and impacts at appropriate times during Project implementation.

21. **CORDAID with the MOHCC, will update its ESMF to provide clear guidance according to the ESF principles and Good International Industry Practice and by applicable national provisions regarding the implementation of project activities.** The updated ESMF will be shared and consulted with stakeholders and publicly disclosed no more than 45 days after project effectiveness. The Infection Control and Waste Management Plan already contains measures for infection prevention and control as well as medical waste management including those relevant for vaccines.

22. **This project is of special importance in that it goes beyond compliance with Bank Environment and Safety Standards to support environmental sustainability with the US\$1.575 million grant ESMAP grant.** Through this grant, the project will support TA, energy efficient and climate friendly equipment and measures to ensure required cold storage and other project goals.

E. Implementation

Institutional and Implementation Arrangements

23. **CORDAID will continue to be the Project Implementation Entity (PIE).** Given that the GOZ is still in arrears and unable to function as the fundholder for WB funds, the HEPRTF and ESMAP funds will be managed by the Catholic Organization for Relief and Development Aid (CORAID) which has been the Project Implementing Entity (PIE) for WB projects in Zimbabwe's health sector since 2011. CORDAID is currently the PIE for the ongoing WB-GFF-financed HSDSP AF V which has a COVID Response Component.

24. **The PIE will work closely with the MOHCC-Project Coordination Unit (PCU) which will, in turn, coordinate with the COVID-19 Emergency Operations Committee at national and sub-national levels.** The PIE will second staff to participate in the COVID-19 coordination committees across pillars. The PIE will handle all World Bank-HEPRTF-ESMAP funds. It may contract UN agencies such as UNDP to procure equipment and goods. In addition, since the MOHCC has delegated the National Pharmaceutical Company (NatPharm, a state-owned enterprise) to handle storage and distribution of all COVID-related goods and equipment, the PIE will enter into an agreement with NatPharm provided that an action plan has been agreed and measures are in place to ensure that storage and distribution risks are addressed. The PIE will ensure that all project goods and equipment are geo-tracked and monitored to confirm that they reach target facilities. Similar to what is being done in HSDSP AF V, complementary mechanisms building on existing systems such as electronic health records and electronic logistics MIS to verify receipt of goods and services will be implemented. To cross-check the validity of the information received on the availability of equipment, supplies and services, the PIE will mobilize Provincial RBF Officers, as well as Health Center Committees which include community representatives from youth groups, women's associations, religious entities, etc. In addition, the PIE's Governance Specialist will guide and review compliance of project processes and interventions including progress made in the project's governance



and accountability action plan.

25. **Additional positions for the PIE to manage the proposed project will be required.** They are a Social Specialist and a Monitoring and Evaluation Specialist. In HSDSP AF V, the Communications Officer also functions as a Social Specialist but the increased activities for risk communication and community engagement to be supported in the new project will require a separate Social Specialist. Similarly, the M&E Specialist complement current staff (Database Manager and Data Analyst) and an incoming Operations Research Analyst. Other needed staff will be confirmed during Appraisal.

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APPROVAL

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