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APPRAISAL STAGE

Report No.: AB4664

Project Name	Swaziland Health, HIV/AIDS and TB Project
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Project ID	P110156
Borrower(s)	KINGDOM OF SWAZILAND
	Government of Swaziland Kingdom of Swaziland
Implementing Agency	
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A. Country and Sector Background

1. Swaziland is a lower-middle income country, one of the few IBRD countries in Africa, with a population of about 1.0 million. It comprises essentially one ethnic group — the SeSwati nation. In 2007, Swaziland had a Gross Domestic Product (GDP) per capita income of US$2,520[1]. The estimated Gross National Income (GNI) per capita, often taken to be a more realistic reflection of individual household income levels was US$ 2,400[2] per capita in 2008. Income distribution, however, is heavily skewed; 54.6% of the wealth is held by the richest 20% of the population compared to 4.3% of wealth held by the poorest 20% with a Gini coefficient of

[1] Data taken from http://data.un.org/CountryProfile.aspx?crName=Swaziland
[2] Data taken from Swaziland Country at a Glance, with information produced from Development Economics LDB database, December 9, 2009.

51%.[3] 69%[4] of the population lives below the upper poverty line of E 71.07 (US$ 9.50) per capita per month.

2. *Swaziland's economy has deteriorated in recent years*. GDP growth for 2009 is estimated to have fallen -0.5%, this represents a decline of 3.2% from 2008. While the prospects for 2010 are slightly better, with GDP predicted to rise by 0.3%, this is far below the 5% required for basic development. Approximately 60% of government expenditures are financed annually from Southern Africa Customs Union (SACU) receipts. Although this mechanism will continue, Swaziland's share of the SACU receipts is expected to decline by approximately 50% in 2010/2011[5] according to World Bank/IMF estimates. This will have a major impact on overall government spending, with implications on health sector spending. The government also has concerns about the growth in recurrent spending, rising from 27.8% to 32.9%[6] of GDP, driven primarily by increases in wages and salaries.

3. *Swaziland's middle-income status is misleading from a human development perspective*. The Demographic and Health Survey (DHS) 2006-2007 indicates that Swaziland is off track to meet its health Millennium Development Goal (MDG) targets with MDGs 4 and 5 worsening – maternal mortality ratio (MMR) increased from 229 per 100,000 live births (in l997) to 589 per 100,000 live births (in 2006/07) and infant mortality rate (IMR) increased from 67 per 1,000 (in 1996) to 85 per 1,000 (in 2006/7). Average life expectancy at birth has fallen from 60 years in 1997 to 43[7] years in 2007. This represents a decline of almost 50%, and is one of the lowest life expectancies in the world. The Human Development Index (HDI) rose from 0.535 in 1980[8] to 0.641 in 1995 then declined to 0.572 in 2007. Health outcomes are worsening due to high levels of HIV/AIDS and TB, and limited progress with maternal, neonatal and child health (MNCH).

4. Swaziland has the highest prevalence of HIV in the world. HIV prevalence is 26% among the sexually active population (15-49 years), with infection rates higher among women (31%) than men (19%) are.[9] Almost one in two women aged 25-29 are HIV positive. In 2009, approximately 90%[10] of those in need were receiving antiretroviral (ARV) treatment. Despite the country's efforts to respond to the HIV/AIDS epidemic, with increasing assistance from development partners, the disease has overwhelmed Swaziland's weak and inefficient health service delivery system and the country has not been able to reverse worsening health outcomes associated with high levels of HIV/AIDS.

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[3] Data from 2009 National Health Sector Strategic Plan, based on the Poverty Reduction Strategy and Action Plan (PRSAP) 2006.
[4] *Yingcamu*, Poverty Reduction Strategy and Action Plan (PRSAP) 2006.
[5] BTOR, IMF Article IV Mission – Swaziland, November 17 – December 2, 2009.
[6] Budget Speech 2010, presented by Majozi V. Sithole, Minister of Finance to Parliament, 2/26/10.
[7] Tables for the Key Findings from Census 2007, Central Statistical Office, Swaziland, available at http://www.gov.sz/home.asp?pid=75
[8] Swaziland Country Fact Sheet, UNDP Human Development Report 2009 available at http://hdrstats.undp.org/en/countries/country_fact_sheets/cty_fs_SWZ.html
[9] Swaziland Demographic and Health Survey (DHS) 2006-2007.
[10] Table 7: Number of people actively on ART in 2007 and 2009, Swaziland Country Report March 2010, Monitoring the Declaration of the Commitment on HIV and AIDS (UNGASS) available at http://data.unaids.org/pub/Report/2010/swaziland_2010_country_progress_report_en.pdf

5. *Satisfying the needs of growing numbers of OVC is increasingly challenging.* Approximately one third of Swazi children (about 144,000) are estimated to be orphans and vulnerable children (OVC) and the number is expected to grow further.[11] According to the DHS 2006-7, OVC are less likely to have their basic material needs[12] met than non-OVC (61 percent compared to 77 percent), and the percentage of OVC *decreases* as the wealth quintile of the household they reside in increases (from 37 percent in the lowest quintile to 22 percent in the highest). The percentage of children who were orphaned or vulnerable increases rapidly with age, from 18 percent of children younger than 5 years to 43 percent of children in the age group 15-17 years. Overall, 11 percent of OVC were underweight as compared to 7 percent of non-OVC. In terms of school attendance, there is very little difference between OVC and non-OVC (slightly over 90 percent of them aged 10 to 14 attend school[13]). In 2006, 43 percent[14] of Swazi households were hosting orphans.

6. *Tuberculosis (TB) has become a major public health problem.* The AIDS epidemic has also *g*iven rise to a concurrent TB epidemic in the country. Recorded new cases rose from less than 1,500 in 1993[15] to over 9,600 in 2007. TB is the biggest killer of PLHIV; it accounts for over 50% of all deaths and over 25% of hospital admissions. HIV co-infection is estimated to occur in over 80% of all TB cases. The TB case detection rate (57%) and cure rate (42%) are also far below the internationally accepted targets of 70% (detection) and 85% (cure).

7. *Infant mortality rate (IMR) and maternal mortality ratio (MMR) have worsened over the last decade to levels equivalent to those last seen in the 1980s.* Despite good antenatal care (ANC) attendance and a relatively high proportion of institutional deliveries, Swaziland has a high maternal mortality ratio (MMR). In 2006-2007, for example, the MMR was estimated to be 589 (per 100,000 live births) compared to MMR of 370 (per 100,000 live births) in 2000 and the national target of 140 (per 100,000 live births). Most maternal deaths occur during childbirth and the postpartum period. The infant mortality rate (IMR) increased from 67 per 1,000 (in 1996) to 85 per 1,000 (in 2006/7), with 25% of all infant deaths taking place in the neonatal period.[16] The main causes of this are preterm delivery, asphyxia, and infections. The high MMR and IMR indicate deficiencies in the provision of emergency obstetric and neonatal care (EmONC) services. The report on *Improving Quality of Maternal and Neonatal Health services in Swaziland: a Situational Analysis* (conducted by MOH/World Bank/UNICEF/WHO/UNFPA in January 2010) which assessed 59 key health facilities confirmed these deficiencies.

[11] OVC is defined as a child (below the age of 18) who (a) has lost one or both parents and/or (b) a child who has a very sick parent, or who lives in a household where an adult has been very sick, or has died in the past 12 months (as defined in the DHS 2006-7). Note that the DHS excludes children in institutional settings (e.g., orphanages) and therefore provides a conservative estimate of the true number of vulnerable children.

[12] In the DHS 2006-7 children were considered to have their basic material needs met if they had a pair of shoes, two set of clothes, and at least one meal per day.

[13] DHS 2006-07.

[14] DHS 2006-07.

[15] Data on TB rates and cases is taken from the National Health Sector Strategic Plan 2008-2013, Ministry of Health, Swaziland, 2009.

[16] http://www.who.int/whosis/mort/profiles/mort_afro_swz_swaziland.pdf

8. *There is an unequal distribution of health facilities and personnel in Swaziland*. Swaziland has 223 health facilities, of which 44.8% are Government owned.[17] While there are 80 health facilities in Manzini region, there are only 34 health facilities in Shiselweni region. Shiselweni region[18] also has the least number of midwives and doctors, and no obstetrician. There are 1.77 midwives per 100,000 population in Shiselweni compared to 3.47 midwives per 100,000 population in Hhohho region. Likewise, there are 0.43 doctors per 100,000 population in Shiselweni compared to 0.84 doctors per 100,000 population in Hhohho region.

9. *Unequal access is influenced by the types of services offered across health facilities*. Although 80% of the Swazi population lives within an 8km radius of the nearest health facility, only around 63% can access a health facility within a one-hour walk.[19] Furthermore, 80% of health facilities are clinics without maternity care, and only 12% of health facilities have in-patient beds and provide only the most basic services. This suggests that actual access to primary health care is much weaker than the 80% figure suggests.

10. *There is much inefficiency in the functioning of health and social welfare institutions in Swaziland*. Inefficiency in the health system is evidenced by, inter alia, low hospital bed occupancy, a lack of standardized protocols, the absence of a *rational* essential care package, deficient supply systems, inefficient recruitment procedures, and poor staff retention at all levels of the health system. The latter is worsened by the impact of a brain drain to South Africa. Similar inefficiencies are evident in the implementation of the social safety net, including assistance for children and pensioners. The Department of Social Welfare (DSW), for example, notes that there are duplicate payments made to some children, while others are not receiving any support; late payments; leakage; and few economies of scale in the information and institutional systems that support the administration of social assistance grants.

11. *The GOS has emphasized health as a priority on the national agenda.* The 2009 National Health Sector Strategic Plan (NHSSP), for example, identifies critical areas in the health sector that require support, and aims to improve low health outcomes and inefficiencies. In addition, high levels of the Swazi Government have emphasized health as a key sector in Swaziland's plans for growth and development.[20] This is evident in the Poverty Reduction Strategy and Action Plan[21] (PRSAP), which stresses the vulnerability of the population, especially the poor, to HIV/AIDS, economic shocks and food insecurity.

12. *In addition, the government has substantially increased its expenditure on health.* Both the health budget and public expenditure per capita on health have shown strong increases over the last three years. An increasing level of resources, both absolutely and proportionately, are allocated to health, although the overall allocation remains below 15%. Per capita spending in

[17] Service Availability Mapping (2007), Ministry of Health, Swaziland.
[18] Table 8, *Improving Quality of Maternal and Neonatal Health services in Swaziland: a Situational Analysis* report, World Bank, WHO, UNFPA, and Ministry of Health, January 2010.
[19] MoHSW 8th round sentinel surveillance report.
[20] Prime Minister's Speech to both houses of Parliament, Government Programme of Action 2008 -2013, March 2009; Budget Speech 2010, presented by Majozi V. Sithole, Minister of Finance to Parliament, 2/26/10.
[21] Yingcamu – Towards Shared Growth and Empowerment – A Poverty Reduction Strategy and Action Programme, September 2007.

nominal terms reached over US$100 (E966) for the first time in 2008/09, rising from E486.97 in 2006/07.

13. *A new Health, HIV/AIDS and TB project is proposed to support the Government in its commitment to improve the health status of Swazis and by addressing some of the most pressing health sector challenges noted above*. This project will be jointly financed by the World Bank and the European Union (EU).[22] Specifically, the proposed project will contribute to: (i) the reform and enhancement of the institutional capacity of the MOH to improve efficient and effective performance of core health sector functions at all levels; (ii) increase access to essential, quality health services; and (iii) increase social safety net access for OVC through a cash transfer pilot.

B. Objectives

17. The *Swaziland Health, HIV/AIDS and TB Project* has two main sectoral foci: a primary focus on the *health sector and the services it delivers* to the Swazi population, and a secondary focus on *social protection* to mitigate the impact of HIV/AIDS on OVCs.

18. The Project Development Objectives (PDOs) are: (i) to improve access to and quality of health services in Swaziland with a particular focus on primary health care, maternal health and TB, and (ii) to increase social safety net access for OVC through a cash transfer pilot.

19. Progress towards achieving these objectives will be monitored by the following key performance indicators (KPIs):

- Percentage of selected health facilities that provide at least five public health services to 80% of intended levels of service coverage.[23]
- Percentage of births delivered by a skilled attendant in a health facility.[24]
- TB case detection rate.[25]
- Percentage of OVC beneficiaries that receive timely cash transfers (as defined in the Implementation Manual).

C. Rationale for Bank Involvement

20. *The proposed project is fully consistent with the Interim Strategy Note* (ISN) for Swaziland (2008-2010), which was approved by the Board in March 2008. The strategy identifies: (i) fighting HIV/AIDS, (ii) improving governance, and (iii) increasing competitiveness as the main development issues facing the country. The ISN proposed a scaling up of the World

[22] Preparation of this project has taken over two years for a number of reasons. These include: the GOS's reluctance to borrow funds for HIV/AIDS, combined with their desire to develop a full national health strategy before agreeing on the content of this project; staff turnover at the MOH; and adjustments to the project to meet changing circumstances, changing priorities, and changing inputs from development partners.

[23] The five public health services, one of the four components of the essential health care package (EHCP), will be defined once the EHCP is finalized.

[24] This data will be obtained from a representative sample survey, such as the DHS. Where such data is not available, it will be collected through estimates using routine statistics.

[25] This includes both smear-positive and smear-negative TB.

Bank's (IBRD lending) program in Swaziland, with a focus on two sectors — health (in particular, HIV/AIDS) and local government.

21. *The proposed project is aligned with previous and current World Bank support being provided in the health sector*. Since 2003, the World Bank has supported the MOH through analytical work. Most notable amongst these is analytical work done under a special arrangement by the Africa Region Vice President for a rapid response stand-alone technical assistance fund.[26] This was the first such fund approved by the World Bank on an exceptional basis, to respond to the unique situation of Swaziland having an overwhelming HIV/AIDS epidemic but being an IBRD country, and hence being unable to benefit from the IDA funded Multi-Country HIV/AIDS Program (MAP) for Africa. In addition, the proposed project builds on the current World Bank health project in Swaziland: "Delivering Maternal Child Health (MCH) Care to Vulnerable Populations Project."[27] The project aims to increase the demand for and access to MCH services in the Lubombo region through interventions such as transport vouchers, recruitment of lay counselors, and performance-based incentives to communities based on achievement towards key MCH indicators.

22. *With recent changes in the aid architecture for health, there have been increasing calls at global and national levels for the World Bank to concentrate on health systems strengthening* (HSS). The project is consistent with both the Bank-wide and Africa Region HNP Strategies,[28] which stress the Bank's comparative advantage in addressing health systems bottlenecks. In addition, the World Bank also has extensive experience designing and implementing social protection programs. The specific actions selected under the project are in line with the Bank's core competencies.

23. *The project is aligned with the Bank's comparative advantage*. Using its technical expertise and significant experience working across sectors globally, this project will focus on high impact interventions, which respond to both the HIV/TB co-epidemic, and challenges faced in primary health care (PHC) and EmONC, whilst also attempting to increase the capacity of the MOH, DSW, and National Children's Coordination Unit (NCCU). In addition, the World Bank can add value to the project due to its significant operational experience in designing and implementing cash transfer programs in Latin America and Asia. Lessons learnt will be applied in the design of the cash transfer for OVC in Swaziland.

24. *The proposed project is consistent with Government priorities for national development, health and HIV/AIDS*. The National Development Strategy (NDS) (Vision 2022) was adopted in 1997 with a 25-year outlook prioritizing human development. The 2006 Poverty Reduction Strategy and Action Plan (PRSAP) operationalized the Vision 2022 by aiming to halve poverty

[26] Additional analytical work includes reviews of the Mbabane General Hospital,[26] the Phalala Fund,[26] the 2009 Modes of Transmission Study and the Quality, Relevance and Comprehensiveness of Impact Mitigation Services Survey (QIMS). In addition, the World Bank has also recently conducted an *Improving quality of Maternal and Neonatal Health services in Swaziland: a situational analysis* of over 50 health facilities, undertaken by the MOH/World Bank/UNICEF/WHO/UNFPA, January 2010.

[27] This project is funded by a $2.57 million grant from Japan Social Development Fund (JSDF) grant and became effective in January 2010.

[28] The World Bank Strategy for Health, Nutrition, and Population Results (April 2007); and Improving Health, Nutrition, and Population Outcomes in Sub-Saharan Africa: The Role of the World Bank (December 2004).

by 2015 and eradicate it by 2022. The National Health Sector Strategic Plan 2008 – 2013 (NHSSP) identifies critical areas in the health sector that require support, and aims to improve low health outcomes and inefficiencies. NHSSP goals are translated into specific objectives and activities with designated roles, responsibilities, budget and monitoring indicators.

25. In 2009, the National Emergency Response Council on HIV/AIDS (NERCHA) developed a five-year (2009-2014) multi-sectoral National Strategic Framework (NSF) to guide the response to HIV and AIDS. The NSF programs are grouped under four thematic areas: (i) prevention; (ii) treatment, care and support; (iii) impact mitigation; and (iv) response management. The Revised National Plan of Action (NPA) for Children 2011-2015 recognizes the challenges posed by an increasing number of orphans and child-headed households. The NPA also highlights the fact that the traditional extended family, which has been the safety net for vulnerable children, has been "under extreme strain as a result of the loss of many family breadwinners and relatives," and emphasizes that government, civil society, and communities must collectively address the issues through public policy implementation strategies to meet the needs of children. While prevention and treatment of HIV/AIDS are largely supported by donors such as the USG President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GFATM), the other two NSF priorities require urgent attention.

26. *The project supports implementation of the MOH's NHSSP and Annual Action Plan 2010-2013 (AAP).* The MOH's NHSSP aims to enhance health system capacity and performance, and has recently operationalized this strategy in the AAP. The World Bank and the EU, as key partners in the Health Partners Coordination Consortium, have agreed to support specific areas of the NHSSP; in particular to fill financial and capacity gaps in the areas of HIV/AIDS, TB, maternal and neonatal health (MNH), OVC, capacity building and overall governance, management and planning in the health sector. Guided by this, and cognizant of the worsening economic forecasts for Swaziland, this project will focus on seeking to improve the quality, access and efficiency of health sector expenditures, and emphasis will be placed on helping the GOS to increase its return on investments in the health sector. This strategic principle underpins the World Bank's engagement in Swaziland.

D. Description

27. The design of this jointly financed project derived from close consultations with the Government, EU and development partners, and NGOs. A premium was placed on ensuring alignment with national strategic plans and objectives; major financial, capacity and program gaps; the need to adopt a harmonized approach and reduce transaction costs; and the importance of focusing on results to improve both performance and efficiency.

28. Based on these project design principles, the challenges faced by the health and social welfare sectors, and the existing support to the sectors from the Government and other development partners, the project comprises three main components. These are: (i) Strengthening the Capacity of the Health Sector, (ii) Facility-level support to Improve Access, Quality and Efficiency of Services, and (iii) HIV/AIDS Impact Mitigation. Components and their associated sub-components are outlined below.

Component 1: Strengthening the Capacity of the Health Sector (US$ 3.90million)

29. This component will support interventions to strengthen the capacity of the MOH at different levels with respect to governance, management and planning. The component will support improvement of the regulatory framework for health service providers, establishment of accreditation review criteria and systems, establishment of a standard care package, quality assurance, oversight and coordination.

30. The project will support efforts to improve governance and health care regulation through the development of a regulatory and accreditation framework, and ultimately a regulatory unit. This includes: (i) further development of the essential health care package of services; (ii) review of the legal and regulatory framework, and development of regulations to incorporate international and regional health agreements; (iii) establishment of a program to develop an accreditation system for personnel, facilities and services; and (iv) support and training for the parliamentary oversight committee and professional regulatory bodies (Medical and Dental, Nursing, Allied Health Councils).

31. Improving governance and management at district-level by: (i) supporting efforts to re-energize and better establish the credibility of the four Regional Health Management Teams (RHMTs), including management development, team building, and organizational and administrative reform to support their work,[29] such as clarification on the roles and responsibilities of RHMTs versus health facilities and improved planning and management skills in a decentralized environment; and (ii) establishing/strengthening hospital boards and improving hospital management through better planning, enhanced professional training, and increased autonomy.

32. Planning and Coordination: (i) strengthening the Health Planning Unit, concentrating particularly on development of planning and budgeting skills and capacity; and (ii) limited support for enhancing the Sector-wide Approach (SWAp) processes that are still at an early stage.

33. Fiduciary: (i) support for financial management systemic reforms and their introduction, especially around improved responsibility centers (i.e. cost) and their delegated authority (with Ministry of Finance); and (ii) additional support for the continuing procurement reforms within the MOH.

Component 2: Facility-level Support to Improve Access, Quality and Efficiency of Services (US$ 23.95 million)

34. This component will support interventions to rehabilitate and improve targeted facilities at different levels of the health system. Management and technical skills training as well as the rehabilitation and equipping of selected clinics, health centers and hospitals will be carried out to improve the access, quality and efficiency of the services provided by these facilities. The

[29] Support to administrative and organizational reform will not entail human resources restructuring or laying off personnel.

Project will have a particular focus on Primary Health Care (PHC), the HIV and TB Co-epidemic Response and Emergency Obstetric and Neonatal Care (EmONC). The project will also support health care waste management to mitigate the environmental risks at the facilities receiving support.

Sub-component 2a: Support to Hospitals, Health Centers and Clinics

35. This sub-component will entail: (i) developing and disseminating guidelines and protocols; (ii) rehabilitating/renovating selected hospitals, health centers and clinics; (iii) providing essential equipment and supplies; (iv) strengthening the referral and transport system; and (v) building skills and capacity to manage health facilities (to be coordinated with support under Sub-component 1a) .

36. This sub-component will also take an integrated approach to health systems strengthening and will address the following aspects:

37. ***Improving PHC:*** The project will provide support for the infrastructure rehabilitation of selected clinics and health centers, including physical and utility upgrading, as well as equipment and a maintenance plan for building and equipment. This activity will be underpinned by the MOH providing appropriate human resources for the rehabilitated facilities based on the essential health care package of services at the clinic and health center levels.

38. ***Strengthening TB and HIV Co-epidemic Response:*** Activities include: (i) community-based interventions for early diagnosis and treatment adherence; (ii) strengthening TB infection control (IC) at the facility level; (iii) provision of digital x-rays at regional and national level; and (iv) training of health workers on managing TB/HIV. These activities are intended to better calibrate aspects of the response currently not funded by the government or other donors, and respond to priorities identified in the AAP on control and management of TB.

39. ***Improving maternal and neonatal health care, focusing on EmONC.*** This support will entail: (i) development and dissemination of detailed EmONC guidelines and protocols; (ii) rehabilitation of health center, clinic and hospital maternity wards through provision and upgrading of essential EmONC equipment and supplies, and training in the use of procured equipment; (iii) on-the-job training of midwives and medical doctors in EmONC, postnatal care, post-abortion care and neonatal care; (iv) strengthening the referral and transport system; (v) development of maternal and perinatal death review guidelines; and (vi) training of health personnel in record-keeping and analysis to increase capacity for monitoring MNH outcomes.

40.

41. ***HealthCare Waste Management (HCWM):*** The project is likely to result in increased generation of health care waste at the targeted health facilities. As such, this component will provide support for the appropriate management of health care waste. A Health Care Waste Management Plan (HCWMP) has been prepared which provides proper guidelines for comprehensive health care waste management to prevent, reduce and mitigate environmental health impacts on facility staff and the public caused by poor health care waste management. The HCWMP approach involves reinforcing the national legal framework for HCWM in Swaziland, improving and strengthening of the institutional arrangements, improving HCWM in health facilities, providing training for health care staff and other health care waste practitioners

on acceptable waste management practices, raising awareness among the general public on risks associated with health care waste handling, and development of a monitoring system for the implementation of the HCWMP.

Sub-component 2b- Support to the nursing training institutions

14. This sub-component will support the capacity building of the nurse training institutions (University of Swaziland Faculty of Health Sciences, Nazarene College of Nursing and Good Shepherd Nursing School). This will entail: (i) development of a national strategic plan for nursing and midwifery; (ii) rehabilitation of training facilities; (iii) strengthening management capacity; (iv) revision of training curriculum to ensure Basic EmONC skills for midwives; and (v) development of guidelines and manuals for mentorship and preceptorship.

Component 3: HIV/AIDS Impact Mitigation (US$ 6.17 million)

42. This component aims to increase social safety net access for OVC through a cash transfer pilot project. The component will build the capacity of the Department of Social Welfare (DSW), provide technical support for the design of a cash transfer pilot for OVC, and put in place systems required to implement this pilot project. Once adequate systems are in place and the DSW capacity has been built, this component will also provide cash transfers to households caring for OVC. The component will consist of the following two sub-components:

Sub-component 3a - *Capacity Building and System Strengthening*

43. Under this sub-component, support will be provided for: (i) Development of the Implementation Manual (IM), outlining the implementation modalities for the pilot project. A consultancy firm, with extensive experience in designing and implementing similar programs, will be contracted under the project to support the DSW in the development of this IM. Lessons learned from previous cash transfer experience in Swaziland and cash transfer programs in other countries will be taken into consideration in this process; (ii) Preparation of a payment mechanism for the cash transfers. The consultancy firm will also support the DSW in the process of selecting a suitable payment mechanism for the cash transfers to ensure efficient, timely and secure delivery of the cash transfer; (iii) Design and establishment of a computerized Management Information System (MIS) for the project. The consultancy firm will help the DSW develop an MIS system that will gather all the relevant project data on, for example, beneficiary households characteristics, cash transfer payments that have been made etc.; (iv) Technical assistance and training for DSW and NCCU in relevant skills to implement the cash transfer pilot. The consultancy firm will also provide customized training on how to implement the cash transfer pilot. Resources will also be provided through this component for communication activities to increase Government officials' awareness and knowledge about cash transfer projects and its potential benefits; and (v) External monitoring and evaluation will generate important lessons learned from the pilot to inform a potential scale-up of the project. The latter will include spot checks/citizen report cards and an impact evaluation study, focusing on the effect of the piloted cash transfers in areas such as household consumption, health, nutrition and schooling.

Sub-component 3b – *OVC Cash Transfer Pilot*

44. This sub-component will pilot the design and implementation systems developed under sub-component 3a, through the provision of cash transfers to households caring for OVC. OVC is defined as a child (below the age of 18) who (a) has lost one or both parents and/or (b) a child who has a very sick parent, or who lives in a household where an adult has been very sick, or has died in the past 12 months (as defined in the DHS 2006-7). Given the high number of OVC in the country and the limited coverage of the pilot project, the support will focus on the poorest OVC. Poverty indicators will be developed to identify the poorest households caring for OVC. Thus, the project will increase access to social safety nets for these selected OVC. The basic objective of the cash transfer pilot is to support poor OVC to meet their basic needs (in the DHS 2006-7 children were considered to have their basic needs met if they had a pair of shoes, two sets of clothes, and at least one meal per day). This objective will be further refined in the process of developing the IM, based on consultations with key stakeholders and with technical support provided through this component. Other potential benefits of the cash transfers are contribution to improved human development indicators for the benefiting OVC in areas such as health, nutrition and schooling. It has also been agreed that the pilot will be implemented in four constituencies through a gradual scale-up. Criteria to select the constituencies will be developed with support from the Swaziland Statistics Office. The project will provide cash transfers to OVC for a period of approximately 3 years and will generate lessons for potential future expansion of the cash transfer project using government or other donor funds.

E. Financing

Source:	($m.)
Borrower	2.0
International Bank for Reconstruction and Development	20.0
EC: European Union	19.0
Total	41.0

F. Implementation

Partnership Arrangements

45. The proposed project will be jointly financed by the World Bank and the EU. The financing will consist of the EU grant (14.5 million Euro or US$ 19.0 million equivalent) and World Bank loan (US$20.0 million).

46. The EU grant will be managed through a World Bank-administered trust fund. Per standard EU/World Bank practice, an Administrative Agreement will be signed when the World Bank Board and the EU European Development Fund (EDF**)** Committee approve the project. This Agreement will clearly stipulate the modalities of the partnership arrangements as well as the roles and responsibilities of both organizations during project implementation and supervision.

47. This partnership arrangement will reduce the transaction costs and result in a reduced net overall financial burden for the GOS through the combination of the EU grant and IBRD loan for project financing. This will also facilitate approval from the Swazi Cabinet[30] and Parliament.

Institutional and Implementation Arrangements

48. As far as possible, implementation arrangements have been designed in alignment with national processes and systems. This should contribute to both sustainability and improved coordination. The MOH will have overall responsibility for implementing Component 1 (Strengthening the Capacity of the Health Sector) and Component 2 (Facility-level Support to Improve Access, Quality and Efficiency of Services), while the DPM's Office will be responsible for implementing Component 3 (HIV/AIDS Impact Mitigation).

49. The overall project will be guided by a Steering Committee (SC) consisting of the Principal Secretaries from the Deputy Prime Minister's Office, Ministry of Finance (MOF), Ministry of Economic Planning and Development (MEPD), Public Service Commission (PSC), Ministry of Health, and Ministry of Public Works (MPW); and the EU Delegation to Swaziland will have an observer role. The SC will be responsible for providing oversight to the project and making policy decisions to facilitate project implementation. It is expected that the SC will be chaired by the Principal Secretary (PS) MOF and meet at least twice a year or as needed.

50. The existing MOH Policy & Planning Committee (P&PC) will have technical oversight of project activities under Component 1 and 2. The appointed Project Coordinator will be a civil servant seconded by the MOH, satisfactory to the World Bank, to assist in ensuring integration of project activities within the MOH and to build sustainable capacity in the Ministry to manage donor-funded projects. Moreover, a long-term Technical Assistant consultant will be recruited for up to two years to support the Project Coordinator in implementing the project under World Bank-financing guidelines. The Project Coordinator will be an *ex officio* member of the Policy & Planning Committee, meaning that the Project Coordinator will participate in meetings, but will not have any vote in decision-making.

51. The responsibility for implementation of day-to-day activities and follow up with MOH technical departments will lie with the Project Implementation Team (PIT), led by the Project Coordinator, which will be accountable to the MOH Planning Unit. The PIT will include two Financial Management Specialists (1 senior and 1 intermediate specialist), two Procurement Specialists (1 senior and 1 intermediate specialist), and Technical Assistance (consultants) to be recruited to support implementation. The intermediate Financial Management and Procurement Specialists will provide support to the Deputy Prime Minister's Office in FM and Procurement for 50% of their work time. An M&E officer will also be appointed. The six staff (Project Coordinator for the MOH Project Implementation Team, Project Coordinator for the DSW Project Coordinating Team, two Procurement Specialists and two Financial Management Specialists) will be recruited or appointed by project effectiveness. Project staff will be situated within the MOH's Planning Unit, with the Project Coordinator reporting to the head of that (expanded) Unit.

[30] Cabinet approval is required before negotiations.

52. The MOH PS will delegate day-to-day management of the project to the Project Coordinator. As the project includes a substantial renovation of the existing MGH buildings, health centers and clinics, the PIT will also enter into a consultancy contract with a firm of architects/quantity surveyors to provide supervision and advice for these civil works.

53. For components 1 and 2, names of technical teams for respective sub-components have been provided by the MOH, e.g. Chief Nursing Officer and Training Officer for Sub-component 2b--support to the nursing training institutions. The heads of these Units will be responsible for the implementation of project activities, which fall under their respective areas. The MOH will appoint focal persons who will lead project implementation of respective sub-components. In some cases, the recruitment of additional staff or long-term technical advisers may be needed to strengthen these technical units and ensure prompt implementation. The technical focal persons and advisers are expected to work closely with the PIT.

54. Coordination between units within the MOH, as in most countries, has been challenging. Following Cabinet approval in late 2009, the MOH is currently planning a major reorganization to radically improve the functioning and effectiveness of the MOH. Cognizant of this, the project is designed to support this reorganization through capacity building. Internal MOH coordination at present is managed largely through a series of "working groups" on a wide variety of topics and personal contacts. In the interim, the project will use the current system. The project will implement activities through the central MOH and its constituent four regional offices following current established practice and division of labor. The regional offices coordinate with the local traditional authorities and communities. Existing arrangements for coordination with development partners, especially those linked to the evolving sector-wide approach will continue. The Project Coordinator will be responsible for regular reporting on project progress and issues to senior management and the technical committee — and to other forums as appropriate. These arrangements will ensure the harmonization of project related policy and operational decisions with implementation.

55. For component 3 and the DPM's office, a project coordination team (PCT) will also be established. The coordination unit will be housed in the DSW. In terms of project management and administration, a Project Coordinator will be seconded from within the DPM's office, but he/she will be supported by technical assistance for two years. It has also been agreed that a project accountant and an M&E officer will be assigned to support the PCT. In addition, the intermediate financial management specialist and procurement specialist recruited for the MOH PIT will allocate half of their time to the DPM's office. It is anticipated that there will be particular need for financial management support once the payments for the cash transfers are initiated. The PCT will also be supported by short-term technical assistance for system development and training. Further details on implementation arrangements for this component will be determined during the development of the program design and implementation manual.

56. Project reports will be compiled separately by the MOH and DPM's office covering their respective activities, and submitted to the World Bank in a timely manner.

Sustainability

57. Swaziland finances a large proportion of its government expenditure from its own resources, despite the changes in circumstances with the SACU receipts. Current concerns about the implications of reductions in SACU revenue for Swaziland will be addressed through project efforts to increase efficiency in utilizing available resources for the health and social sectors and thereby help the GOS get "more health and safety net for the money."

58. Positions recruited under the project are critical in improving the efficiency and effectiveness of the MOH and DPM's Office to fulfill their respective roles and manage ongoing activities. The incremental recurrent costs arising from these positions are modest since additional staff positions are already planned for in the reorganization of the MOH, and can be absorbed by the MOH and DPM budget. In addition, while significant resources will be earmarked for health infrastructure rehabilitation, priority has been placed on renovation of existing infrastructure with the aim of ensuring their functionality. In order to mitigate the contingent liabilities arising from health infrastructure related works, construction of new facilities will not take place under this project. Based on discussions with both sectors, the recurrent project costs from the recruited positions are well within the regular budget envelopes of the sectors.

59. This project will also finance a significant amount of technical assistance (TA). The Sexual and Reproductive Health Unit, for example, will receive TA during project implementation to monitor and reinforce the protocols, training and equipment provided by the project. Similarly, the MOH Planning Unit will benefit from focused technical assistance in planning and coordination and develop the enhanced capacity to coordinate donor, NGO and MOH activities for the health sector. By the end of the project, the Health Partners Coordination Consortium should be playing a greater role.

60. DSW and NCCU will receive TA and system support through the project to maintain the OVC database and effectively manage or scale up the OVC cash transfer mechanism. Several development partners have already expressed interest in providing funds for cash transfers to OVC, once a reliable and well functioning cash transfer system is in place. The skills and systems built with the project's support will remain with MOH and DPM, enabling them to use their resources more efficiently to produce better results.

61. The financial impact of the project on government's health spending will be felt mainly in terms of additional resources for maintenance of renovated facilities as well as repairs and replacements of medical equipment.

Lessons Learned from Past Operations in the Country/Sector

62. Given the limited experience of Swaziland with World Bank projects, the lessons learned in this project are derived from experience with earlier World Bank projects in Swaziland; projects under preparation; other development partner projects in Swaziland; and World Bank experience in designing projects of this nature.

63. *Government ownership and commitment is critical.* The last World Bank project in Swaziland - an urban development project - closed in March 2005 (more than 10 years after it

was approved). The follow-up project has been under preparation since then. Two other projects (on rural electrification and on OVC support) were at very advanced stages of preparation when they were dropped in 2006 and 2003 respectively, due to lack of Government commitment. Cognizant of this, this project prioritized Government commitment and ownership as a key to promoting the project's implementation readiness and success. The task team has engaged in constant dialogue with the highest leadership and technical working levels, and modified the design in response to both the changing needs and priorities of the GOS. In addition, the project is closely aligned with the Government's strategic direction and priorities as identified in the NHSSP, the 2010-2013 AAP, the 2009–2014 NSF and the National Action Plan (2011-2015).

64. Since 2005, the only World Bank-financed operation that has been implemented and completed is a modest Institutional Development Fund (IDF) project, whose objective was to help build and provide capacity for an HIV/AIDS monitoring and evaluation (M&E) system. The IDF project achieved its development objective and was generally considered best practice in design, relevance and timeliness. At project closing in 2006, however, more than one third of the grant was undisbursed.

65. *In an environment in which there is limited Bank experience, there is a need for close collaboration and continuous support.* In recognition of this, the project will provide technical support and fiduciary oversight to MOH/DPM through frequent supervision, site visits and training. In addition, the preparation and adoption of the Project Operations Manual (POM), and procurement staffing and training have been included as effectiveness conditions. Furthermore, a consultant has been recruited in Mbabane to provide on-going operational support, with further support available from the World Bank's Pretoria and Washington, DC offices.

66. *In low-capacity settings, reduced transaction costs for the government are particularly important*. The project will be co-financed jointly with the EU and managed by the World Bank. This will reduce transaction costs and the administrative burden to the Government. This is particularly important given the capacity constraints in Swaziland. Development partners providing support to related areas were carefully consulted in order to avoid duplication and ensure both complementarities and synergy between interventions. A positive externality is that the project will contribute to improved coordination among partners and more efficient resource allocation and management through its support for sector planning and the MOH's proposed SWAp.

67. *Flexibility in design is important for project success*. Given that the health and social welfare context surrounding the HIV/TB co-epidemic is evolving in Swaziland, it is important for the design to maintain flexibility. Indicative component allocations have been made for the project, but the actual allocations will be adjusted based on the MOH's AAP and DPM's annual budget. This will allow the project to respond to the country's emerging needs as well as learning and making course corrections based on project performance and implementation experience.

68. *Project Development Objective (PDO) and Results Framework:* efforts have been taken to define a PDO to which the project funding will realistically contribute. This is supported by a

results framework with indicators linked to a clear results chain, and duly supported by baseline data. Special attention was paid to the use of existing government-driven data collection and information systems.

69. *Managing cost escalation:* This project involves considerable work on health facility infrastructure. Experience from health projects with sizeable infrastructure components supported by other development partners shows that these are often associated with substantial cost escalation. In order to mitigate against possible cost escalation, the detailed feasibility and architectural design studies (including costing) will be completed so that adjustments can be made to the implementation plan before the contracting process begins.

Safeguard Policies

15. The project is classified as Category B - Partial Assessment as it triggers OP 4.01 for environmental assessment because of the anticipated increase in health care waste to be generated by the health care facility centers and the disruptions in normal health care services during the rehabilitation of some of the health care facilities. A HCWMP and an Environmental and Social Management Framework (ESMF) address two key aspects, proper health care waste management and the environmental effects of rehabilitation works, respectively. The HCWM Plan provides: a) measures for addressing shortcomings identified in the HCW management system; b) guidelines for developing a sound legal framework; c) institutional arrangements for proper HCW management in the country; d) appropriate training for health care practitioners; and e) awareness raising strategies for the public while the ESMF provides mitigation measures for rehabilitation negative impacts.

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

G. Documents in the Project File

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* *By supporting the proposed project, the Bank does not intend to prejudice the final determination of the parties' claims on the disputed areas*

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30. Budget Speech, presented by Majozi V. Sithole, Minister of Finance to Parliament, February 26, 2010.
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