Project Information Document (PID)
The project development objective is to improve the coverage and quality of key reproductive, maternal, neonatal, child and adolescent health (RMNCAH), nutrition and NCD services (hypertension and diabetes) in Eswatini.

Components

Component 1: Improve health service delivery to increase the coverage and quality of health services to build human capital
Component 2. Increase community demand for RMNCAH, nutrition and NCD services
Component 3. Strengthen the MOH’s stewardship capacity to manage essential health and nutrition services and project activities
Component 4: Contingent Emergency Response Component

## PROJECT FINANCING DATA (US$, Millions)

### SUMMARY

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B. Introduction and Context

Country Context

1. 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.

2. Although classified as a lower middle-income country (GNI per capita US$2,960), high poverty rates and income inequality challenge Eswatini’s economic and human development potential. While the national poverty rate\(^1\) has fallen in recent years (from 63% in 2010 to 59% in 2017), it remains high, particularly in rural areas (70%) and in two regions (Lubombo (72%) and Shiselweni (67%)). Eswatini’s hunger levels are “serious”\(^2\); almost two thirds of the population are food insecure\(^3\) with detrimental impact on pregnant women and children.

3. 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 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 urged Eswatini to undertake expenditure rationalization.\(^4\) With the Government’s focus on reducing the structural and fiscal imbalances, the 2020-21 budget depicts a positive outlook with a growth recovery up to 2.9% in 2020.\(^5\)

4. 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, including South Africa. 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

\(^1\) The proportion of Emaswati living below the upper bound poverty line of SZL 975.3 per adult equivalent per month (in January 2017 prices)
\(^2\) 2018 Global Hunger Index
\(^3\) EHIES 2017; Word Bank 2020
\(^5\) Kingdom of Eswatini Budget 2020/21 At a Glance, Budget and Economic Affairs Department, Ministry of Finance
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.

5. **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 Government of Eswatini (GOE) recognizes that the cost of not acting could be detrimental and this includes actions beyond the emergency response. Investments today in strengthening the health system are urgent and critical to protect Eswatini’s economic and human capital potentials.

6. **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, emphasizing technology use and innovation to help reach its vision.**

7. **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 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.

8. **Human capital is also a priority for the World Bank.** The proposed project, in line with the GOE’s strategic priorities, focuses on strengthening the health system and community platforms to help address critical human capital challenges, including stunting, child mortality and adult mortality. The project also builds on prior support and lessons from Eswatini engagement and complements efforts by the Government and the World Bank in other sectors to support the human capital agenda, including education and water supply and sanitation.

**Sectoral and Institutional Context**

9. **Eswatini’s HIV epidemic, persistently high maternal and child mortality, increasing non-communicable diseases (NCDs) and malnutrition affect its human capital formation.** Eswatini has the highest HIV prevalence in the world, with more than a quarter (27%) of its reproductive age population living with HIV. While the national HIV response has achieved significant success, particularly in its rapid scale up of antiretroviral treatment and evidenced by a 44% reduction in HIV incidence from 2011 to 2016, challenges remain. HIV incidence is the highest in the world and HIV remains the leading cause of death in the country. Furthermore, high levels of maternal and child mortality and stunting, coupled with a surge in NCDs, further drive Eswatini’s performance on the HCI, particularly in relation to child survival and stunting and adult survival.

10. **The number of maternal and neonatal deaths is high due to failure to provide high quality, responsive care to pregnant women and their babies in health facilities.** Despite increased access to antenatal care (ANC, 76% attend at least 4 visits) and women delivering in health facilities (88%), Eswatini’s Maternal Mortality Ratio

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6 The achievement on the HCI’s health dimensions are: probability of survival to age 5 = 95%; adult survival rate = 59%; not stunted rate = 74%.
remains very high (437/100,000). Most maternal deaths are linked to poor quality of care in facilities including lack of or poor monitoring, substandard management, and delayed intervention and referral. Quality of ANC is also a challenge. Almost all maternal deaths are deemed avoidable, with most deaths associated with obstetric hemorrhage (15% of deaths), hypertensive diseases of pregnancy (8%) and pregnancy related sepsis (8%). While there has been better progress with neonatal mortality (17.2 deaths per 1,000 births), neonatal deaths still account for a third of total under-five deaths. More than 600 perinatal deaths were registered in 2018, of which 27% were recorded as fresh still born, 38% as a macerated still born and 35% as an early neonatal death, pointing to challenges across the continuum of care, from antenatal, delivery and postnatal care. Beyond the neonatal period, mortality among children under five is driven by diarrhea (20% of under-5 deaths), lower respiratory infections (17%), HIV (11%) and protein-energy malnutrition (5%).

11. **Adolescent girls and their babies are particularly vulnerable to poor outcomes.** High teenage pregnancy in Eswatini is a significant barrier to human capital accumulation. While the adolescent fertility rate has declined in recent decades, at 77 births per 1000 girls (2017), it remains very high; it is more than double the rate observed in South Asia for example and up to 30% of all pregnancies in Eswatini are among adolescents. In the large-scale Sitakhela Likusasa Impact Evaluation, almost half (44%) of adolescent girls and young women (AGYW) reported ever being pregnant. The study highlighted the importance of education on health and fertility and the need to strengthen family planning for AGYW; more than half (56%) of participants report having never spoken to anybody about contraception and one in five were not using any contraception despite being sexually active. In addition to its negative impact on girls’ education (two thirds of girls who drop out of secondary education in Eswatini do so as a result of pregnancy) and the consequent risk of HIV, teenage pregnancy significantly contributes to high anemia and malnutrition in adolescents, maternal and child morbidity and mortality and to vicious intergenerational cycles of poor health and poverty. Adolescent girls who become pregnant are more likely to be socially isolated and suffer from depression. They are less likely to attend ANC (67% attend 4 visits vs. 84% in women 35+ years). Their infants are more likely to be born preterm, have a low birth weight, become stunted and die as an infant compared to infants born to older mothers. Infants born to adolescent mothers are also more likely to grow up in an unsupportive home environment, have poor cognitive development, drop out of school, be unemployed or underemployed, and if female, become pregnant in their adolescence, thereby cementing the perpetual inter-generational poverty cycle and contribute to inter-generational cycle of malnutrition. Indeed, a strong negative correlation exists between fertility and human capital (-0.82) and GDP per capita (-0.78).

12. **A triple burden of malnutrition (undernutrition, overnutrition, micronutrient deficiency) adversely impacts Eswatini’s human capital.**

- A quarter of children under 5 years in Eswatini are stunted and 2% are wasted (2014), which is linked to poor breastfeeding practices and quality of complementary foods (low dietary diversity) especially among infants. Stunting is more prevalent in rural (27%) compared to urban areas (19%) and among children living in the poorest (30%) compared to the richest households (9%).

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8 ASA P16353; Confidential enquiry on maternal deaths (2014-2016)
9 Healthy Mothers, Healthy Babies: A Study to Assess Quality of Care in Maternity and Neonatal Services, supported by ASA P163653
11 Conducted as part of the World Bank ASA HIV Incentives Evaluations in Swaziland and South Africa (P151327)
13 MICS 2014; SMART 2017
▪ The prevalence of overweight/obesity is high among women and children. Nine percent of children under 5 years are overweight or obese, with prevalence being higher in urban compared to rural areas (12% vs. 8%) and among children living in the richest (18%) compared to the poorest households (6%). Additionally, more than half of women of reproductive age (51%) are either overweight or obese (18% among men).

▪ The prevalence of micronutrient deficiency is also high among women and children. The prevalence of anemia among women, pregnant women and children under 5 years is 27%, 30% and 42% respectively.

▪ Malnutrition has a long-term negative impact on health, knowledge, skills, and productivity. Malnutrition in the first years of life impacts childhood survival, early childhood development (ECD), learning abilities and educational outcomes in school, with long-term negative consequences for work productivity and economic development. In 2009, the estimated economic impact of child stunting – which was only marginally higher at the time (31%) than current estimates - was SZL 783 million (3.1% of GDP). Stunting puts children at higher risk of NCDs in later life. Obesity also causes NCDs and leads to increased health care costs, reduced work productivity, increased disability and premature deaths. Among women it also contributes to premature deliveries, low birth weight and other poor birth outcomes.

13. The rapid increase in NCD prevalence has resulted in a high number of avoidable morbidities and premature deaths, negatively impacting human capital. NCDs as a cause of mortality increased from 23% in 2007 to 40% in 2017, with most NCD-related deaths linked to cardiovascular diseases and diabetes and kidney diseases. Adult prevalence of hypertension and type-2 diabetes (key risk factors for cardiovascular diseases) is 25% and 14% respectively, with significant drop-offs across the cascade of care, highlighting system-wide deficits, including failures in primary care and inadequate coordination and continuity of care. Currently, the majority of NCD service delivery, including uncomplicated cases, is provided by physician-led teams at tertiary-level facilities. Screening is done on an ad-hoc basis. Furthermore, there are gender disparities in NCDs; while the prevalence of hypertension and diabetes is higher among women, men are less likely to seek care and achieve disease control.

14. The above health challenges are due to shortcomings in Eswatini’s health system foundations that lead to poor quality care, as follows:

Population health needs, expectations and demand
▪ Eswatini’s health system is not aligned with population health needs.
▪ Client experience and satisfaction with health services is low.
▪ Poor utilization of health services is linked to socio-cultural beliefs and practices and lack of knowledge and awareness.

Stewardship, governance and financing
▪ Eswatini’s health system performance is hampered by outdated legislation and weak regulation and accountability and management structures.
▪ While Eswatini’s per capita spending on health (US$233) increased between 2017 and 2019, macroeconomic challenges have led to reduced fiscal space for health.

14 Eswatini 2018 Nutrition Country Profile. Globalnutritionreport.org
19 Per capita health expenditure was estimated about US$233 in 2016, which is above the income group average of about US$60. The most recent 2017/18 National Health Accounts (2019 unpublished draft) indicates significant increase in per capita health spending.
Health system platforms and organization of care
- The success in fighting HIV fragmented Eswatini’s health system, resulting in service delivery silos with significantly different capacity, transparency and performance.
- Eswatini relies on several platforms for health service delivery, organized in five levels.
- Eswatini’s community-based health services requires strengthening.
- Primary health care facilities have been neglected.
- The effective use of hospitals and quality of care in hospitals also requires attention.

The availability of competent and motivated health workers
- Eswatini has a shortage of specialists and an outdated skill mix.
- Competency, performance and motivation among available health workers is a challenge.

Essential medicines, commodities and equipment
- Stockouts of essential medicines and consumables is a challenge in Eswatini.
- The delivery of essential services is hampered by lack of functional equipment due to poor tracking of available equipment and their maintenance and repair needs.

Data and digital health technology
- Eswatini’s electronic medical record, known as the Client Management Information System (CMIS), is available in less than half of facilities (48%) and does not cover, or inadequately covers, all health conditions.
- Other digital health technology is not used extensively in Eswatini, including for client communication and self-monitoring, clinical case management and healthcare provider decision support and referral coordination.

15. To meet the National Health Sector Strategic Plan’s (NHSSP II 2019-23) policy objective – “build an efficient, equitable, client-centered health system for accelerated attainment of the highest standard of health for all people in Eswatini” – the Ministry of Health (MOH) recognizes the need to invest in health system strengthening to improve the coverage of essential services and the quality of care. The recent coronavirus outbreak has underscored the importance of a responsive and resilient health system. Modernizing the foundations of the health system and applying evidence-based improvements are key to achieving better quality care and, through that, reduced child and adult mortality and stunting for human capital formation.

16. The proposed operation will support the MOH and the GOE to: (1) progress with the implementation of the NHSSP II (2019-23), which promises all Emaswati Universal Health Coverage; (2) improve service delivery; and (3) advance Eswatini’s human capital agenda. The project will complement and support significant government investments in these areas.

17. The proposed project complements the Eswatini COVID-19 Emergency Response Project (P173883) and is designed to deepen and extend its investment impact through focusing on medium-term structural changes and the modernization of the health sector. While the emergency operation focuses on short-term needs to support capacity in prevention, detection, and response to the threat posed by the COVID-19, this operation offers a medium-term horizon to strengthen the health system’s foundations and its preparedness to respond to the population’s health needs, including through strengthened health facilities that can provide high-quality care to COVID-19 patients and those with chronic diseases that are particularly susceptible to severe coronavirus disease, digital platforms for real-time responsive data tracking and use, and governance and stewardship to efficiently and effectively manage the health response in such a dynamic environment.
C. Proposed Development Objective(s)

Development Objective(s) (From PAD)
The project development objective is to improve the coverage and quality of key reproductive, maternal, neonatal, child and adolescent health (RMNCAH), nutrition and NCD services (hypertension and diabetes) in Eswatini.

Key Results
The PDO level indicators will be as follows:
(1) Percentage of patients diagnosed with hypertension and diabetes who are managed at the PHC level (coverage)
(2) Percentage of children U5 provided with a basic package of nutrition specific services (coverage)
(3) Percentage of pregnant women receiving at least 4 ANC visits that meet defined quality standards (quality)
(4) Percentage of health facilities that meet a minimum standard of quality as measured by a Health Facility Quality Index (quality)\(^\text{20}\)
(5) Percentage of adolescents served or reached with quality sexual and reproductive health services

D. Project Description

18. To address key sector challenges and support the achievement of the PDO, the proposed project would be financed by an IBRD loan of US$20 million, using an Investment Project Financing (IPF) instrument, over a five-year period. The project will focus on strengthening the health system and ramping up investments in reproductive, maternal, neonatal, child and adolescent health (RMNCAH) services as well as nutrition and non-communicable diseases (hypertension and diabetes) to address critical human capital challenges, including stunting and child and adult mortality, applying a life course approach. The project includes the following components:

Component 1: Improve health service delivery to increase the coverage and quality of health services to build human capital (US$14.5 million)

19. This component will improve health service delivery to integrate and scale up quality nutrition and NCD services in Primary Health Care and improve the quality of RMNCAH services across the continuum of care. Under this component, the project will (i) build the capacity of health-care workers to deliver high-quality RMNCAH, nutrition and NCD services in PHC and higher-level care for continuity; (ii) increase the availability of drugs, commodities, functioning equipment and client data to support the delivery of these services through supply chain strengthening and investments in a digital health system; and (iii) strengthen the capacity of facilities, programs and regions to monitor quality of care, provide supportive supervision and implement a Quality Management Approach in facilities to ensure that the above inputs are translated into effective and high-quality service delivery.

Sub component 1.1 Build capacity of healthcare workers to deliver enhanced, high impact RMNCAH and nutrition and NCD services across the continuum of care (US$3.0 million)

20. This sub-component will build the capacity of healthcare workers to deliver essential and high-quality RMNCAH, nutrition and NCD services across the continuum of care through trainings, the provision of digital decision support tools (‘digital job aids’), and the creation of a Community of Practice for midwives as a platform for sharing best practices and creating new knowledge for continuous professional development.

\(^{20}\) The index will be tailored to level of care to reflect differences in service profile at the primary and hospital levels.
**Sub component 1.2 Increase the availability of drugs, commodities, functioning equipment and client data for high-quality health and nutrition service delivery in facilities (US$9.5 million)**

21. This sub-component will increase the availability of drugs, commodities, functioning equipment and client data in facilities critical for RMNCAH, nutrition and NCD service delivery through strengthening of supply chain management and investing in a digital health system. Procurement of biomedical equipment and supplies for hygiene and sanitation will supplement COVID-19 healthcare readiness in hospitals and health facilities.

**Sub component 1.3. Strengthen the capacity of facilities, programs and regions to monitor quality of care, supervise and implement a Quality Management Approach in health facilities (US$2.0 million)**

22. This sub-component will help ensure that the above inputs translate into the delivery of high-quality services by strengthening the capacity of facilities, programs and the Regional Health Management Teams\(^{21}\) (RHMT) to supervise, monitor and implement a Quality Management Approach (QMA) for high-quality RMNCAH, nutrition and NCD service delivery. The QMA is central for outcome-oriented service organization and management, strengthening the link between health spending and health outcomes. Implementing the program will enable linking quality of care performance to an accreditation process.

**Component 2. Increase community demand for RMNCAH, nutrition and NCD services (US$2.0 million)**

23. In addition to supply side constraints, utilization of RMNCAH, nutrition and NCD services is also affected by demand side constraints, including insufficient knowledge on prevention and care seeking and cultural barriers. This component will strengthen the Community Health Volunteers (CHV) program, conduct targeted Social Behavior Change Communication (SBCC) and develop client-based digital applications to address social and behavioral bottlenecks and generate demand for quality and service delivery uptake of RMNACH, nutrition, and NCD services. Specifically, the project will support:
   - Strengthening the CHV program to conduct community sensitization and outreach.
   - Scale up of Social Accountability Monitoring of Sexual and Reproductive Health (SRH) Services.
   - Targeted Social Behavior Change Communication.
   - Design, develop and scale-up of client-based digital applications to help generate awareness, improve knowledge and boost uptake of services and adherence to appointments and treatment.

**Component 3. Strengthen the MOH’s stewardship capacity to manage essential health and nutrition services and project activities (US$3.5 million)**

24. This component focuses on strengthening the stewardship capacity of the MOH to manage health and nutrition services and project activities. It will also support engaging with the Central Agencies and other line ministries that are critical for the implementation of the proposed sector strengthening and modernization to build human capital, supported by a Human Capital Liaison. Specifically, the project will provide technical assistance (TA) to support the drafting of updated regulations, policies and strategies including for the draft Health Bill, professional regulatory bodies, National Quality of Care Framework, public-private partnerships, nutrition, health care waste management (HCWM), including the capture or combustion of fugitive methane emissions and health financing. Technical assistance and training for the MOH will also be provided on leadership and management to support modernization and organizational transformation of the MOH; strategic Human

\(^{21}\) The RHMTs are responsible for monitoring and supervising all health facilities and services within their respective region.
Resources for Health (HRH) planning; health planning and financing (including budget planning and monitoring, strategic purchasing); service contract development, negotiation, management, and revision; service delivery organization; climate change and health, and monitoring and evaluation. This will be complemented with twinning arrangements, particularly relevant during the first 12-18 months of project implementation. The gradual reforms supported under this component are instrumental for the success of the interventions proposed under Components 1 and 2; it situates the micro-level\(^{22}\) efforts as part of the broader reforms to sustain their impact.

25. **Project Management and Monitoring and Evaluation:** To ensure effective and efficient project implementation, this component will also support the MOH with fiduciary aspects (financial management and procurement), project evaluation, and environmental and social standards. This will ensure the timely management of procurement of goods and services, financial reporting and audits, consistent and quality data flows for the Results Framework and operational research purposes, and compliance with environmental and social requirements and the Environmental and Social Commitment Plan (ESCP). This component will support the functions of the Project Implementation Unit, which will move toward integrated project management, as well as the relevant functions of the inter-ministerial technical committee and the inter-ministerial policy advisory group as they relate to the implementation of the project.

**Component 4: Contingent emergency Response Component (CERC) (US$ Zero)**

26. The project includes a CERC in accordance with the World Bank Policy: Investment Project Financing, paragraph 12 and 13, for situations of urgent need and assistance. This component will allow for rapid reallocation of project proceeds in the event of a future natural or man-made disaster or crisis that has caused or is likely to imminently cause a major adverse economic and/or social impact during the life of the project. Such events may include a disease outbreak. An assessment using the World Bank’s Climate and Disaster Risk Screening Tool determined that Eswatini is vulnerable to risks because of climate change impacts including droughts, extreme temperature and inundation due to extreme precipitation and flooding. The CERC will have no funding allocation initially. In the event of a future emergency, this component would allow the GOE to request the World Bank to recategorize and reallocate financing from other project components to cover emergency response and recovery costs, if approved by the World Bank.

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**Summary of Assessment of Environmental and Social Risks and Impacts**

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22 Micro-level interventions focus on a narrow set of solutions, such as increasing health system inputs and changing people’s behaviors and routines at the point of care, i.e. at the lowest (micro) level of the health system. Kruk et al. 2018.
27. The environmental and social risk classification of the project is Moderate under the World Bank’s Environmental and Social Framework (ESF) based on the type and nature of the project that will support strengthening of health systems for human capital development in Eswatini. The project has a relatively small footprint with limited construction activities. The construction that will be undertaken relates to Component 1 the “Construction of an Integrated Operations Centre with upgraded fleet.” The project will construct and purchase related office equipment for an integrated Operations Centre to house the medical supply chain unit, a medical equipment maintenance workshop (managed by Biomed) and a data warehouse for information technology. The Operations Center will be built on the premises of an existing facility and will be undertaken primarily on land already owned the Ministry of Health - Central Medical Stores and it is expected that there will be minimal and mostly temporary impacts. Under Component 3, the project will support TA that will help the preparation of a costed Health Care Waste Management Strategy for which implementation may not be undertaken during the project period. The project activities will also involve support to improving sector governance and performance, health financing, service delivery, supply chain management, infrastructure and equipment maintenance, and health management information systems will require: (1) procurement of equipment, including electronic equipment; and (2) capacity building and training in the application of analytical computing skills, setting up and use of various computer-based and other management systems, and the use and maintenance of infrastructure and equipment. The environmental impacts associated with these activities will result from the generation and disposal of electronic waste (e-waste) which is considered to have moderate environmental risk, and general waste (paper, packaging, redundant non-electronic equipment, food waste etc.) considered to have low risk.

28. The social risk rating of the project is moderate at this stage as the project does not involve any significant social impacts that could harm communities and individuals. The project footprint is relatively small with limited and manageable adverse social impacts that can be mitigated with the application of appropriate mitigation measures. The likely social impacts include gender-based violence/sexual exploitation and abuse, spread of HIV, etc., that may result from the limited labor influx and workers coming together in one place during the construction of the operations center. Other impacts may include exclusion of the vulnerable from the project’s benefits. The MOH will need to strengthen citizen engagement and beneficiary feedback mechanisms that will ensure inclusion and active participation from vulnerable groups, as well as its capacity on social risk management and stakeholder engagement, since currently the Ministry (through the Department of Environmental Health) has developed its expertise only in environmental risk monitoring.

E. Implementation

Institutional and Implementation Arrangements

29. Project Management. The project will be implemented by the MOH with support of an agile Project Implementation Unit (PIU). To enhance coordination and ownership, the PIU will be housed within the MOH and integrated in the MOH’s operational and management structure. The PIU will report to the Principal Secretary (PS). The primary functions of the PIU will be to coordinate effective implementation of the project and serve as the vehicle for capacity building and skills transfer to MOH staff in the areas of Financial Management (FM), Procurement, Environmental and Social (E&S) Risk Management, and M&E. The PIU will consist of at least seven full time MOH staff (Project Coordinator, Financial Controller, Principal Accountant, Senior Procurement Officer, M&E Officer, E&S Officers, and Secretary) and seven technical staff to be hired under the project (i.e. Human Capital Liaison (1), Senior FM Specialist (1), Procurement Officer (1), Senior Evaluation Officer (1), E&S Officers (1), and Technical Officer (1)).
(2), and Oversight Project Engineer (1)). The technical support on FM and M&E is for the duration of the project. The Human Capital Liaison would support the MOH for the first 24 months of the operation; a critical time for cross-sectoral coordination and operational planning. The Liaison will provide interface between the key human capital components, assuring cohesion with education, social protection and health. For Procurement and E&S, support is anticipated to be for the first 18-24 months of project implementation to accelerate implementation and provide sustainable knowledge transfer to MOH staff. To support the environmental and social development agendas in a sustainable manner, E&S will be integrated at the regional and community levels, using the existing platforms and cadres (e.g. Regional Health Inspectors, Community Health Volunteers, Social Accountability Officers). The PIU will be headed by a Project Coordinator, who will facilitate integrated implementation between project components and the activities of the MOH. The Project Coordinator will support harmonized policy, strategy, and operational processes that span departments/functional areas.

30. For operational efficiency, the Project Implementation Unit’s (PIU) technical roles (fiduciary, M&E, environmental and social) are shared between this project and the project implementation team for the Eswatini COVID-19 Emergency Response Project (P173883), which was approved on April 20, 2020 and is expected to become effective in April 2020. The MOH assigned MOH employees to establish the shared PIU. Sharing MOH staff and technical consultants will improve the strategic scope while reducing the overhead costs across the two projects. Tapping into technical surge capacity early on will accelerate effectiveness. The Coordinators for the two projects (P173883; P168564) will ensure that the project implementation responsibilities are organized in a way to harness operational benefits and reduce operating costs.

31. MOH Technical Leadership. To strengthen technical capacity in areas that are critical for project effectiveness and to enable and equip the MOH to manage sector modernization, the following departments/units will receive initial technical assistance (surge capacity) to support design and implementation: (1) HRH Unit: 1 Senior TA to support HRH strategy development and implementation, HRH analyst; (2) Health Services Directorate: PHC Focal Team to catalyze primary care revitalization and improve service delivery organization; (3) Health Planning Unit: 1 Senior TA to support on health financing/strategic purchasing; (4) Strategic Information Department: 1 Senior TA to support data flow, data generation and data analysis for decision making. The assistance will include skill transfer and support transition management. This TA would also provide guidance for the M&E Officer in the PIU to ensure robust project evaluation.

32. Project governance beyond the MOH includes an Inter-ministerial Technical Committee, to be convened and chaired by the Under-Secretary Technical of the MOH, and an Inter-ministerial Policy Advisory Group that would consist of the Principal Secretaries of the MOH and Central Agencies and report to the Secretary to the Cabinet to inform Cabinet and Prime Minister-level engagements. The Inter-ministerial Technical Committee will guide project implementation and its operationalization at the technical level. To avoid creating parallel structures within government administration, this committee will consist of the Sectoral Officers responsible for health in the Ministries of Finance, Economic Planning and Development and Public Service, together with their counterparts in the line Ministries that are relevant for the project’s success, including the Director of Health Services, MOH, the Director of Management Services Division, Ministry of Public Services (MOPS), the Director of the Ministry of Information Technology (MICT), and from ministries related to human capital development. The Inter-ministerial Technical Committee will be convened and chaired by the Under Secretary Technical in the MOH, supported by the Human Capital Liaison, who will provide operational-level coordination between the PIU, the MOH and other ministries / agencies relevant for human capital development. The Liaison will provide a critical interface between the key human capital
components, assuring cohesion with education, social protection and health. The scope of this body will be to review and discuss technical aspects that require coordination with the Central agencies and with line ministries and prepare joint reports / proposals for the Inter-ministerial Advisory Group, for its information, guidance or decision.

- **Inter-ministerial Policy Advisory Group** will consist of the PS of the MOH, the Central Agencies, and the Chief Economist of the MOEPD. The role of this body will be to inform Cabinet-level decision-making and policy formulation, in alignment with Eswatini’s development priorities. The Policy Advisory Group will report to the Secretary to the Cabinet to inform Cabinet and Prime Minister-level engagements.

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## APPROVAL

<table>
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<tr>
<th>Task Team Leader(s):</th>
<th>Edit V. Velenyi</th>
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### Approved By

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<tr>
<th>Environmental and Social Standards Advisor:</th>
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<tr>
<td>Practice Manager/Manager:</td>
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<td>Country Director:</td>
<td>Asmeen Khan</td>
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<td>29-Apr-2020</td>
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