MINISTRY OF HEALTH AND CHILDCARE

ZIMBABWE HEALTH SECTOR DEVELOPMENT SUPPORT PROJECT (HSDSP)

ENVIRONMENTAL AND SOCIAL MANAGEMENT FRAMEWORK (ESMF)

Prepared for:
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Prepared by: -

Sibekile Mtetwa
Environmental and Social Safeguards Specialist
5 Soden Avenue
Upper Hillside
Hillside
Harare
Zimbabwe
mikemtetwa@live.com

The Zimbabwe Health Sector Development Support Project Additional Financing-V (HSDSP AF-(V)) Environmental and Social Management Framework (ESMF) is intended to provide complete documentation for the requirements of a holistic Environmental and Social Safeguards management system for the project. This ESMF contains the findings of a study conducted for the health sector of Zimbabwe and the instrument has been developed based on local conditions and findings.

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Attention: The Secretary of Health
Ministry of Health and Childcare
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Zimbabwe

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FOREWORD

The Constitution of Zimbabwe give every citizen and permanent resident of Zimbabwe the right to have access to basic health-care services, including reproductive health-care services. Environmental rights enshrined in the constitution of the republic also give every Zimbabwean the right to a clean environment that is not harmful to their health and well-being. It is on this basis that the National Development Strategy 1 (NDS1) notes that the country continues to face multiple Water, Sanitation and Hygiene (WASH) challenges, environmental challenges among others, pollution, and poor waste management. Currently poor health care waste management is one of the pertinent issues confronting the health sector throughout Zimbabwe. The Covid-19 pandemic compounds the challenges.

The Government of Zimbabwe (GoZ) through the Ministry of Health and Child Care (MoHCC) has received funding for the World Bank-Global Financing Facility for the Zimbabwe Health Sector Development Support Project, Additional Financing-V (HSDSP AF-(V). The HSDSP AF-(V) is a continuation and enhancement of the ongoing Health Sector Development Support Project (HSDSP) which is a US$53 million grant-funded project which has been supporting the GOZ to increase coverage and quality of maternal and child health (MCH) services using a Results Based Financing (RBF) approach for the last decade and has had four additional funding since its approval in September 2011. The HSDSP AF-(V) will also assume an expanded function of catering for the response to COVID-19 Pandemic. The period of implementation is from December 2020 to April 2023.

The HSDSP AF-(V) will comprise various sub-projects with different levels of environmental and social impacts and located at various locations throughout the project districts. The sub-project activities will affect their physical and social environments, necessitating the preparation of this Environmental and Social Management Framework (ESMF). The ESMF has been prepared as a guide for the various activities of the proposed project and how to assess and mitigate any negative environmental and social impacts, which would require attention prior to project implementation. This ESMF is to be used by the HSDSP AF-(V) project to ensure that all environmental and social safeguards are adequately addressed. The actions and activities in this ESMF will be underpinned by enablers such as capacity building, education and training, research, monitoring and review as well as awareness raising of all stakeholders to better understand and participate in project implementation to improve the environmental and social performance of the project. The framework advocates for effective stakeholder engagement, strengthening of Environmental and Social Impact Assessments (ESIA), institutional arrangements to improve implementation and enforcement. The MOHCC hopes that implementation of this framework will improve environmental and social risk assessment, risk planning, reduction, mitigation and stakeholder participation.

Lastly, we would like to thank the World Bank-Global Financing Facility and Cordaid for the technical assistance and all those who made it possible to have this Environmental and Social Management Framework.

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Air Commodore (Dr) J. Chimedza
Permanent Secretary for Health and Child Care

LIST OF ABBREVIATIONS

ACFP	Archaeological Chance Finds Procedure
ACRWC	African Charter on the Rights and welfare of the Children
AIDS	Acquired Immunodeficiency Syndrome
CBOs	Community Based Organisations
COVID-19	Corona Virus Disease 2019
CRC	Convention on the Rights of the Child
DoR	Department of Roads
DDF	District Development Fund
DC	District Councils
E&S	Environment and Social
EA	Environmental Assessment
EHSG	Environment, Health and Safety Guidelines
EIA	Environmental Impact Assessment
EMA	Environmental Management Agency
EOC	Emergency Operations Committee
ESIA	Environmental and Social Impact Assessment
ESMF	Environmental and Social Management Framework
ESMP	Environmental and Social Management Plan
ESSC	Expanded Supply Side Community
FFS	Food and Food Standards
FTCT	Fast Track COVID-19 Facility
GBV	Gender Based Violence
GDP	Gross Domestic Product
GFF	Global Financing Facility
GIIP	Good International Industry Practice
GoZ	Government of Zimbabwe
GRM	Grievance Redress Mechanism
HCRW	Health Care Risk Waste
HCW	Health Care Waste
HCWM	Health Care Waste Management
HIV	Human Immunodeficiency Virus
HSDSP AF-(V)	Health Sector Development Support Project, Additional Financing-V
HPA	Health Professions Authority
HSSP	Health Sector Strategic Plan
ICWMP	Infection Control and Waste Management Plan
IECCD	Integrated Early Childhood Care and Development
LMP	Labour Management Procedure
M&E	Monitoring and Evaluation
MNCH	Maternal, New-born and Child Health
MoHCC	Ministry of Health and Child Care
MOPSLSW	Ministry of Public Service, Labour and Social Welfare
MLGPW	Ministry of local Government, and Public Works.
MECTHI	Ministry of Environment, Climate, Tourism and Hospitality Industry (MECTHI)

NAC	National Aids Council
NEP	National Environmental Policy
NGO	Non-Governmental Organization
NIHR	National Institute of Health Research
NIP	National Implementation Plan
NMMZ	National Museums and Monuments of Zimbabwe
OAU	Organisation of African Union
OHS	Occupational Health and Safety
PHC	Primary Health Care
PCU	Program Coordination Unit
PDO	Programme Development Objective
PIE	Project Implementing Entity
POPs	Persistent Organic Pollutants
PPE	Personal Protective Equipment
PRS	Poverty Reduction Strategy
RBF	Results Based Financing
RMNCAH-N	Reproductive Maternal, Neonatal, Child, and Adolescent Health and Nutrition
SEA	Sexual Exploitation and Abuse
SI	Statutory Instruments
TA	Technical Assistance
UN	United Nations
UNDP	United Nations Development Programme
UV	Urban voucher
CHW	Community Health Workers
WASH	Water, sanitation, and Hygiene
WB	World Bank
WHO	World Health Organization

EXECUTIVE SUMMARY

Background

The Government of Zimbabwe (GoZ) through the Ministry of Health and Child Care (MoHCC) is in the process of preparing the Zimbabwe Health Sector Development Support Project, Additional Financing-V (HSDSP AF-(V)), with World Bank (WB) technical and financial support. HSDSP AF-(V) is a continuation and enhancement of the ongoing Health Sector Development Support Project (HSDSP; P173132), which is a US$53 million grant-funded project which has been supporting the GOZ to increase coverage and quality of maternal and child health (MCH) services using a Results Based Financing (RBF) approach for the last decade and has had four additional funding since its approval in September 2011. The HSDSP AF-(V) will also assume an expanded function of catering for the response to COVID-19 Pandemic.

Cordaid Zimbabwe will be the Project Implementing Entity (PIE) and will receive World Bank-GFF funds through a Designated Account. It will purchase services for the urban RBF and the voucher program and expand its implementation responsibilities in collaboration with the MoHCC to cover provincial and central hospital quality-focused RBF, ESSC RBF, and COVID-19 emergency response. The MoHCC Program Coordination Unit (PCU) will continue to be the national purchaser for RBF services in the 18 rural districts being supported by the HSDSP.

Rationale for the ZHSDSP ESMF

The potential socio-economic benefits of the HSDSP AF-(V), are increased coverage and quality of essential reproductive maternal, neonatal, child, and adolescent health and nutrition (RMNCAH-N) services, whilst enhancing the country's COVID-19 epidemic emergency preparedness and response. The interventions have positive implications for the cognitive and socio-economic development of individuals and long-term physical well-being and growth, with benefits disproportionately accruing to the most vulnerable. However, HSDSP AF-(V) will comprise various sub-projects with different levels of environmental and social impacts and located at various locations throughout the project Districts. The sub-project activities will affect their physical and social environments, necessitating the preparation of environmental and social safeguards instruments, in this case an Environmental and Social Management Framework (ESMF).

The ESMF is a tool to examine the risks and impacts when a project consists of a programme and/or series of subprojects and the affected persons, risks and impacts cannot be determined until the programme or subproject details have been identified. In the case of this project, while the types of activities are known, while their locations, size, capacity, and other details are not yet established, hence the need for an ESMF.

This ESMF has been prepared as a guide for the various activities of the proposed project and how to assess and mitigate any negative environmental and social impacts, which would require attention prior to project implementation. This ESMF is to be used by the HSDSP AF-(V) project to ensure that all environmental and social safeguards are adequately addressed and that the relevant capacity building and training needs are established for the recommended measures to be implemented effectively. Furthermore, the ESMF has been prepared as a guide for the integration of environmental and social considerations into the design, planning and implementation of the proposed programme activities. It also provides

a basis for specific environmental and social assessments of all sub-projects to be carried out under this proposed World Bank financing.

The ESMF Development Process

The ESMF development process consisted of the following aspects:

(i) establishment of baseline socio-environmental conditions,
(ii) review of policy, regulations, institutional framework,
(iii) assessment of potential environmental impacts,
(iv) assessment of potential social impacts,
(v) preparation of the environmental mitigation plan and a monitoring plan,
(vi) providing guidelines for the implementation of the measures.

The process involved extensive review of related literature from published and unpublished documents, field surveys and investigations and a high degree of consultations with the various stakeholders. The rationale for these extensive consultations is to take on board views from a cross section of the stakeholders, at least from local level, district level, and central government level in the health sector and related sectors.

Overall, the ESMF will ensure that the substantive concerns of the relevant World Bank Safeguards Policies and the Zimbabwean legislation will be considered during the implementation of the HSDSP AF-(V) activities.

Policy, Legal and Institutional Framework

The policy and legal review established that the HSDSP AF-(V) programme will be supported by a host of laws, regulations and institutions that promotes sustainable activities to strengthen, protection of the health environment and well-being of the people of Zimbabwe. The said instruments are guided by the governing laws and the Constitution which majors on sustainable development and the management of the environment so that current generation benefits but without endangering future generations' full rights to the environment and benefits as well.

The World Bank remains committed to mainstreaming social, environmental and climate change solutions into World Bank financed projects, thus HSDSP AF-(V) was designed and informed by the World Bank's Environmental and Social Safeguards Policies. The Safeguards Policies serve to ensure the identification, avoidance and management of potential environmental and social risks and benefits associated with Bank operations. The ESMF describes a process that will ensure that the substantive concerns of the relevant World Bank Safeguard Policies and Zimbabwe legislation are addressed during the implementation of the selected activities. However, where the Bank Operational Policies (OP) are more stringent than the national standards, the Bank OPs will prevail.

Programme Categorization

The environmental categorization for AF-V remains "B", since the issues being supported are a follow-up of the previous additional financing phases with a few additional activities. The issues are Category "B" because their risks and impacts are considered moderate, site-specific, temporary, predictable, and readily managed through project design features and mitigation measures. The additional minor works also have a small footprint, with limited and

manageable adverse environmental impacts that can be mitigated and managed with the application of appropriate mitigation measures. The project will continue to support strengthening of medical waste management and disposal systems in permanent and temporary healthcare facilities on an as needed basis since the main environmental issue associated with this project's activities is health care waste management.[1]

Environmental and Social Assessment Process

In order to ensure that potential environmental and social impacts are identified and ultimately adequately addressed, a number of safeguards instruments have been developed for this project and they include i) the Environmental and Social Management Framework (ESMF), ii) the Infection Control and Waste Management Plan (ICWMP), iii) the Indigenous Peoples Planning Framework (IPPF), and iv) the Grievance Redress Mechanism (GRM).

The safeguards instruments, like this ESMF were developed with stakeholder consultations, which are part of an overall continuous stakeholder consultation process described in this ESMF. The process involves identifying the concerned/affected stakeholders for each subproject, soliciting their views and continuously checking if their views are being taken care of as the project implementation progresses.

Because of the current limitations imposed by the COVID-19 Pandemic, full-scale site visits could not be conducted. The strategy that was applied included the following:

- Limited site visits,
- Several Virtual Zoom Meetings done with some of the key stakeholders like MoHCC management, Environmental Management Agency (EMA) head office, etc,
- Administration of an electronic questionnaire was done to all key stakeholders in MoHCC, participating Ministries, and Agencies.

The ESMF emphasizes the need for continuous consultations with stakeholders throughout the programme cycle to achieve successful implementation and monitoring. The Project Implementing Entity (PIE) will have the responsibility to effectively engage stakeholders in achieving the project objectives for the benefit of all.

An important facet of the stakeholder consultation process is the **Grievance Redress Mechanism (GRM).** The GRM will be a system by which queries or clarifications about the project will be responded to, problems with implementation will be resolved, and complaints and grievances will be addressed efficiently and effectively. The GRM was developed from what is generally being practiced in the Health Facilities. It will mainly serve the purpose of responding to the needs of beneficiaries and addressing and resolving their grievances.

[1] Temporary health care facilities will need to factor in safe water, sanitation, and hygiene facilities (meeting quality standards; separation of infected vs. non-infected patients).

Environmental and Social Concerns and Mitigation of Impacts

The potential associated impacts were analysed and mitigation measures for the identified impacts proposed. The planned minor improvements in water and sanitation and the refurbishments of facilities will not have any significant environmental impacts. However, the enhanced health delivery system will result in an increase in the generation of infectious waste. Therefore, the main safeguards issues will be related to the management of infectious healthcare waste and the occupational health and safety of workers handling the waste and illnesses including the new COVID-19. Smaller scale impacts will be the generation of small amounts of construction waste from the upgrading, renovation and WASH facility installation activities. The WASH activities will include at least one water tank and three toilets installed per sub-project. The longer-term issue will be to ensure that the WASH facilities installed are properly maintained and that their waste is properly handled to avoid small-scale pollution.

The ESMF then establishes a unified process for addressing all environmental and social issues in sub-projects from preparation, through review and approval, to implementation. The Project has an Infection Control and Waste Management Plan (ICWMP) to govern the management of healthcare waste

The proposed mitigation measures for the Zimbabwe HSDSP AF-(V), provide guidelines for the management of potential environmental and social aspects at all possible sub-project sites. The mitigation or enhancement measures will reduce the negative impacts and enhance the positive impacts.

The ESMF places special emphasis on the empowering of women and youth and their protection from any form of abuse. Of note are the measures to avoid, minimize, manage, and mitigate any Gender Based Violence (GBV) / Sexual Exploitation and Abuse (SEA) risks, which may arise especially at the minor refurbishment and installation sites.

Capacity Building

The successful implementation and monitoring of the ESMF, will require that target groups and stakeholders who play a role in the implementation of the ESMF, be provided with appropriate training and awareness. This is necessary because the implementation of the activities will require inputs, expertise and resources which will be adequately taken care of if the concerned parties are well capacitated. Careful and strategic identification of training recipients should be carried out at the beginning of the Project.

Generally, MoHCC and the PIE at national, provincial, district and community levels have limited capacity in the application of the ESMF and the applicable Safeguards Policies.

ESMF Budget

The total estimated amount needed to cover all the work to be carried out under the ESMF preparation and implementation for the sub-projects is **US$266,552.00** for the three years of project implementation. The key indicative aspects that would require a cost budget include training and capacity building for the project PIE; training and capacity building for the project district and local level teams; and Implementation of the stakeholder engagement plan.

Conclusions and Recommendations

The proposed project has potential to significantly improve the country's health delivery system and the emergence response to the COVID-19 pandemic. The improvement in health that the community will benefit, will translate to improved livelihood as people become productive again and this will translate ultimately to an improved economy.

The HSDSP AF-(V) is depicting more positive than negative potential environmental and social impacts. Most of the project's activities will generate insignificant impacts, but the enhanced health delivery system will result in increase in the generation of infectious waste and the occupational health and safety of workers encountering the waste and illnesses including the new COVID-19. These will be mitigated through the implementation of the project's ICWMP which outlines the management of infectious healthcare waste. **These envisaged negative environmental and social impacts will be localized, minimal, short term and can be mitigated. The final benefits of this project to the nation will, by far outweigh any potential negative effects. Further, the project will overall not have any apparent significant environmental and social impacts if the recommended mitigation measures are carried out.**

1. INTRODUCTION

1.1 PROJECT BACKGROUND

The Government of Zimbabwe (GoZ) through the Ministry of Health and Child Care (MoHCC) is in the process of preparing the Zimbabwe Health Sector Development Support Project, Additional Financing-V (HSDSP AF-(V)) with World Bank technical and financial support. As one of the prerequisites for the project through the World Bank, an Environmental and Social Management Framework (ESMF) must be developed.

The Zimbabwe HSDSP AF-(V) is a continuation and enhancement of the ongoing Health Sector Development Support Project (HSDSP; P173132), which is a US$53 million grant-funded project which has been supporting the GOZ to increase coverage and quality of maternal and child health (MCH) services using an RBF approach for the last decade and has had four additional funding since its approval in September 2011.

The HSDSP AF-(V) will assume an expanded function of catering for the response to the COVID-19 pandemic. The Global Financing Facility (GFF) in support of Every Woman Every Child agreed to a request by the GoZ to allocate US$5 million of the proposed US$25 million grant for COVID-19 response activities, as part of the proposed fifth Additional Financing (AF V).

Thus, HSDSP AF-(V) will ensure continuity and quality of essential reproductive maternal, neonatal, child, and adolescent health and nutrition (RMNCAH-N) services, whilst responding to the epidemic. It will be a national programme, comprising various sub-projects with different levels of environmental and social impacts and located at various locations throughout the country. The sub-project activities have a bearing on physical and social environments, necessitating the preparation of environmental and social safeguards instruments that will be used to mitigate against the impacts these sub-projects will impose on the environment. The safeguards instruments for this project include, (i) the Environmental and Social Management Framework (ESMF), (ii) the Infection Control and Waste Management Plan (ICWMP), (iii) the Archaeological Chance Finds Procedure (ACFP), (iv) the Indigenous Peoples Planning Framework (IPPF) and (v) the Grievance Redress Mechanism (GRM).

This ESMF is to be used by HSDSP AF-(V) to ensure that all environmental and social safeguards are adequately addressed and that the relevant capacity building and training needs are established for the recommended measures to be implemented effectively.

1.2 ESMF OBJECTIVES

The ESMF objectives are

- To establish clear procedures and methodologies for the environmental and social assessment, review, approval, and implementation of investments to be financed under Zimbabwe HSDSP AF-(V),
- To specify appropriate roles and responsibilities, and outline the necessary reporting procedures, for managing and monitoring environmental and social concerns related to project investments,
- To determine the training, capacity building and technical assistance needed to successfully implement the provisions of the ESMF,
- To establish the project funding required to implement the ESMF requirements.
- To provide practical resources for implementing the ESMF, including general guidance on development of ESMPs and their implementation.

This ESMF was prepared because the location, design, and magnitude of the impacts of the eventual sub-projects is not yet known at project appraisal stage, even though the types of potential subprojects are well defined. It provides a guide for the integration of environmental and social considerations into the planning and implementation of the HSDSP AF-(V), together with its expanded Emergency COVID-19 Response mandate, that Zimbabwe is proposing. It further provides a basis for environmental and social assessments of all sub-projects to be carried out under this proposed financing.

This ESMF focuses on the nature and extent of significant adverse environmental and social impacts that may result from any of the HSDSP AF-(V) activities including the COVID-19 response and serves as a framework for screening environmental and social issues for all the possible activities that will be undertaken. It establishes a unified process for addressing all environmental and social safeguards issues on sub-projects from preparation, through review and approval, to implementation.

This ESMF also describes a process that will ensure that the substantive concerns of the relevant World Bank Safeguard Policies and Zimbabwe law are addressed during the implementation of the selected response activities.

1.3 PROJECT DESCRIPTION

The following is an outline of the HSDSP AF-(V) Project:

1.3.1 HSDSP AF-(V) Project Development Objective (PDO)

The Project Development Objective for HSDSP AF-(V) is to “Increase coverage and quality of an integrated package of RMNCAH-N services, as well as strengthen COVID-19 response and institutional capacity to manage peformance-based contracts consistent with the Recipents’ ongoing health initiatives”.

1.3.2 HSDSP AF-(V) Project Components

The proposed HSDSP AF-(V) project will continue to support activities that are aligned with the project’s original three components with some modifications based on lessons from

implementation while also including a new component to support the GOZ's COVID-19 emergency response. The HSDSP AF-(V) project's components are:

Component 1: Results-Based Financing in Delivery of Packages of Key Maternal, Child and Other Related Health Services (RMNCAH-N) [Total: US$36.35 million; Government of Zimbabwe: US$27.9 million and World Bank-Global Financing Facility: US$8.45 million]

Sub-Component 1.a. RMNCAH-N: Rural RBF [Government of Zimbabwe: US$21.6 million]
This sub-component will support rural RBF in the 18 project districts and eventually expanding to the remaining 42 rural districts. The RBF package will be expanded from RMNCAH-N, TB, and HIV to include NCDs such as hypertension at primary level and diabetes at secondary care level.

Sub-Component 1.b. Rural Expanded Supply Side Community RBF [Total: US$3.9 million; Government of Zimbabwe: US$1.7 million; World Bank-Global Financing Facility: US$2.2 million]
This sub-component will support the piloting of an Expanded Supply Side Community (ESSC) RBF in line with the Community Health Strategy in four rural districts. In this pilot, community health indicators will be added to the facility performance indicators to form the basis for RBF payments.

The ESSC RBF's main focus will be community mobilization and health promotion by community health workers including HCC members of the following key interventions: (i) WASH, (ii) nutrition, breastfeeding, growth promotion and monitoring, and Vitamin A supplementation; (iii) early pregnancy detection and referral; (iv) reduction of adolescent pregnancies through communication for behavioural change; and (v) early reporting and community psychosocial support for victims of SGBV including linkages/referrals to care. All interventions will incorporate gender mainstreaming through involvement of both females and males in the communities.

Sub-Component 1.c. RMNCAH-N: supply side RBF for provincial and central hospitals focusing on quality of care [Total: US$3.5 million; Government of Zimbabwe: US$1 million and World Bank-Global Financing Facility: US$2.5 million]
This new sub-component will introduce RBF in two central hospitals and reconfigure RBF in 8 provincial hospitals in a phased manner (starting with four provincial hospitals in 2021, then scaling up to an additional four provincial hospitals in 2022), focusing on quality of care. A hospital quality checklist will be developed (for central hospitals) and revised (for provincial hospitals) to form the basis for RBF payment.

For both provincial and central hospital levels with RBF, 75% of RBF payment will be for facility improvement based on an approved operational plan to deliver quality RMNCAH-N services and 25% of RBF payment could be used for staff motivation at the institutional level.

Sub-Component 1.d. RMNCAH-N: Urban RBF [Total: US$7.3 million; Government of Zimbabwe: US$3.6 million and World Bank-Global Financing Facility: US$3.7 million]
This sub-component will support the urban RBF in pilot areas and scale it up to additional municipal health facilities with a possibility of expanding the package to include family

planning for poor pregnant urban women, vitamin A supplementation for their children 18-59 months old, and provision of PEP to SGBV affected poor urban women and their children based on available resources.

This sub-component will also support TA to assess the feasibility of converting the Urban Voucher (UV) pilot into a Health Equity Card (HEC) system to provide a service package focusing on maternal, neonatal and child health and nutrition for the poor.

Component 2. Management and Capacity Building [Total: US$10.5 million; GOZ: US$1.3 million and World Bank-GFF: US$9.2 million]
This component will finance overall program and project management and capacity building. It will also support:

- the GOZ to update and implement the PIM.
- RBF institutionalization and selected innovative approaches to the delivery of RMNCAH-N services at all levels of the health system.
- project supervision including staff and consultants for financial management, procurement, safeguards, governance, and other technical areas.

Sub-Component 2.a. Management and Capacity Building for RMNCAH-N RBF [Total: US$10.25M; Government of Zimbabwe: US$1.3M and World Bank-Global Financing Facility: US$8.95M]
This sub-component will support:

- participating ministries: MOHCC, MOFED, Ministry of Public Service, Labour and Social Welfare (MOPSLSW) and other related Government Ministries to improve capacity to manage project related services including RBF institutionalization and UV scale-up,
- strengthening strategic RMNCAH-N management capacity at national and sub-national levels (provincial, district and facility levels),
- equipment and TA to strengthen the referral system across the four levels of care (primary to quaternary),
- several quality-focused strategic interventions starting with the implementation of the recently completed RMNCAH-N Quality Improvement (QI) Guidelines and other strategic innovations,
- reconfiguring delivery of RBF quality interventions and tools given the COVID-19 pandemic,
- For the Expanded Supply-side Community RBF pilot, this sub-component will support development and operationalization of data capturing tools for community team leaders,
- Information and Communication Technology Department activities.

Sub-Component 2.b. Selected Key Health Financing Reforms [World Bank-Global Financing Facility: US$0.25 million]
This sub-component together with Health Financing TA from the GFF will support implementation of the National Health Financing Strategy especially in providing TA to assist MOHCC with (a) improving resource allocation and expenditure efficiency and (b) strengthening domestic resource mobilization in the health sector to help mitigate the significant risks posed by the country's macroeconomic situation.

Component 3. Monitoring, Documentation and Verification of Results under Performance-based Contracts [Total: US$3.05 million; Government of Zimbabwe: US$0.7 million; World Bank-Global Financing Facility: US$2.35 million]
This component will support monitoring, evaluation, and external verification including counter-verification activities undertaken by the HPA as part of the RBF program.

It will also finance:

- Operational research in collaboration with the National Institute of Health Research to generate evidence and lessons from AF V implementation, and other reviews,
- strengthening project-related mechanisms for grievance redress (GRM) and stakeholder engagement through provision of TA, equipment, and tools to improve current systems within the MOHCC and the PIE.

Component 4. COVID-19 Response [World Bank-Global Financing Facility: US$5 million]
This component will support the GOZ to prevent the spread of COVID-19, prioritizing infection prevention control while also strengthening the focus on results of the national COVID-19 response.

Sub-Component 4.a. Case Detection, Contact Tracing, Recording, Reporting. Specifically, activities will:

- strengthen COVID-19 surveillance systems including detection, recording, and reporting of cases,
- improve laboratory capacity through procurement of Polymerase Chain Reaction (PCR) based laboratory test cartridges,
- support epidemiological investigation and contact tracing,
- provide timely data for decision-making through training of health personnel on the Go-data system.

Sub-Component 4.b. Risk Communication and Community Engagement.
This sub-component will support:

- strengthening of interpersonal communication through community Health Workers (CHWs) and health professionals, non-government organizations (NGOs), Community Based Organisations (CBO and community leaders,
- psychosocial support to health care workers and COVID-19 affected individuals and information and counselling to the community.

Sub-Component 4.c. Infection Prevention and Control (IPC).
This sub-component will support activities to strengthen the public health system's capacity to minimize infection risks for patients and health personnel including:

- PPE kits and IPC-related goods for quarantined cases, rapid response teams and health personnel working in isolation health care facilities and hospitals,
- installation of water tanks in selected isolation centres and supplies for handwashing facilities,
- basic sanitation facilities in critical areas,
- medical waste management and disposal systems in selected permanent and temporary isolation healthcare facilities.

Sub-Component 4.d. Case Management and Related Health System Strengthening.
The sub-component will support strengthening of the public health system's capacity to:

- provide medical care to COVID-19 patients through provision of medical supplies like oxygen concentrators and medical equipment like ICU sets (beds, ventilators),
- fully kitted ambulances for referrals of COVID-19 affected individuals to treatment centres,
- provide food and basic supplies including linen and possibly menstrual hygiene kits for temporary isolation centres and treatment facilities.

Sub-Component 4.e. Response Coordination and Monitoring & Evaluation.
This sub-component will support the MOHCC Coordination Team as part of the National Emergency Operations Committee (EOC) to carry out its coordination functions. It will finance:

- operationalization of video-conference facilities in MoHCC Permanent Secretary Boardroom and sub-national EOC at Provincial Medical Directorates' offices,
- operationalization of the rapid response teams including call centres,
- the development and implementation of a COVID-19 response M&E action plan,
- development and implementation of a stakeholder engagement plan and GRM,
- the establishment of a routine monitoring mechanism for the response which will be based on the RBF Quality Supportive Supervision system sub-national levels.

Support will be provided through TA; training; provision of furniture, equipment, installation of servers in the MOHCC data centre to enhance data storage capacity, procurement and rental of vehicles that will be used for monitoring of activities by the National team, and related operating costs.

1.4 SAFEGUARDS APPROACH

The HSDSP AF-(V) is a continuation and a fifth Additional Financing of the ongoing Health Sector Development Support Project (HSDSP; P173132), which has been supporting the GOZ to increase coverage and quality of MCH services using an RBF approach for the last decade, with an original US$15 million grant having been approved. Therefore, the World Bank Safeguard Policies, as well as the relevant national laws and regulations, still apply to this project.

As the specific location and extent of the rehabilitation, refurbishment or execution of minor health and sanitation works as well as specific expansion of the RBF packages covering prioritized RMNCAH-H and other related services are not identified at this stage, a framework approach has been adopted to assess the potential environmental and social impacts and risks of the HSDSP AF-(V). This entails the development of an Environmental and Social Management Framework (ESMF), together with its supporting instruments like the ESMP, Archaeological Chance Finds Procedure (Appendix 8).

Specific interventions (renovation, reconstruction, refurbishments, upgrades, community-selected etc.) will be identified during project implementation and from a safeguards perspective the Project is operating within a framework approach. The ESMF provides guidelines for screening all subprojects and all project activities, and determination of requirements for assessment, and preparation of any further documentation in accordance

with the World Bank safeguards policies including site-specific environmental and social safeguard instruments like site specific ESMPs.

HSDSP AF-(V) safeguards approach also emphasizes the optimization of land-use, to avoid/minimize adverse impacts such as resettlement footprints, deforestation, landslides/soil erosion and obstruction of communities from their resources.

1.5 POTENTIAL RISKS AND IMPACTS

The HSDSP AF-(V) programme will continue to support modified activities that are aligned with the parent project, together with new activities including COVID-19 emergency preparedness and response. Its classification will continue as Category "B" because its risks and impacts are considered moderate, site-specific, temporary, predictable, and readily managed through project design features and mitigation measures. While the risks associated with COVID-19 and infectious medical waste are serious, with use of personal protective equipment and other behaviors outlined in WHO Guidelines, the risks are manageable and should not result in large-scale or significant impacts. Effective administrative, infection-controls, engineering controls and environmental safety controls must be put in place to minimize these serious risks. The project ICWMP outlines these measures to manage infection control and waste management in the project.

Project activities with environmental and social consequences include:

1. Minor civil works - Renovation/refurbishment/upgrading of facilities including isolation centers and other clinical facilities will involve various minor works inside the building, windows/doors replacement, roofing (if needed), facade works, and necessary improvement of existing infrastructure on the site. Minor works for setting up of emergency health facilities/isolation centers, as well as furnishing and equipping National EOC and sub-national EOCs and rapid response teams are also included.
2. Community level mobilization activities from the Rural Expanded Supply Side Community RBF. The Community Level RBF activities will mainly be promotive (eg WASH education information, etc) and preventive (Vitamin A supplimentation, etc). Each health facility through its Health Center Committee (HCC) will manage funds for these community activities such as community mobilization and health promotion by community health workers including HCC members of the following key interventions: (i) WASH education for behavior (**not facilities or equipment**) however if the HCC identifies a need like a borehole or toilets, the identified need may be installed), (ii) nutrition, breastfeeding, growth promotion and monitoring, and Vitamin A supplementation; (iii) early pregnancy detection and referral; (iv) reduction of adolescent pregnancies through communication for behavioral change; and (v) early reporting and community psychosocial support for victims of SGBV including linkages/referrals to care. All interventions will incorporate gender mainstreaming through involvement of both females and males in the communities.

Table 1-1 Typical subsidy for each community

ITEM TO BE FINANCED	ESTIMATED AMOUNT (US$)
Estimated subisidy for facility in each district per quarter	4609.93
Estimated incentive for Community health workers involved in the project (50% of the facility susbisidy) per quarter	2,304.97
Estimated incentive for Health Care Staff involved in the project (25% of the facility susbisidy) per quarter	1,152.48
Estimate for operational activities for community activities per quarter (25% of the facility subsidy)	1,152.48

The subsidies were divided as follows: 50% for community health workers incentives, 25% for facility improvements and 25% for health care workers incentives. This was because the community health workers will be doing most of the work and will be supported by health care workers to achieve their objectives. If the community health workers were to get 75% of the subsidies as incentives, this would create a discrepancy in which community health workers would earn more than health care workers and that could create conflicts.

The estimated amount of the subsidy for community activities within each facility is US$ 1152.48 per quarter and this will be used for the community activities. This amount is not sufficient to cover all the possible community activities, so the activities must be screened and only the most appropriate for each community will then be financed.

3. COVID-19 Response. Activities will include procurement of medical supplies and equipment, installation of water tanks[2] in selected isolation centers and supplies for handwashing facilities using WHO/UNICEF Joint Monitoring Program (JMP) standards;[3] basic sanitation facilities using JMP standards[4] in critical areas, and (xi) medical waste management and disposal systems in permanent and temporary healthcare facilities as needed. It will finance laboratory test kits, PPE for surveillance and laboratory workers. Appendix 10 is the checklist of safety features for screening laboratories that will be financed by the project.

1.5.1 Social Risks

The key social risks that will arise from the implementation of HSDSP AF-(V) include the following:

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2 Kindly note that the water from the water tanks is expected to be potable quality.

3 Handwashing facilities include a sink with tap water, buckets with taps, tippy-taps, and jugs or basins designated for handwashing. Soap includes bar soap, liquid soap, powder detergent, and soapy water but does not include ash, soil, sand or other handwashing agents.

4 Improved sanitation facilities are those designed to hygienically separate excreta from human contact and include flush/pour flush to piped sewer system, septic tanks or pit latrines; ventilated improved pit latrines, composting toilets or pit latrines with slabs.

(i) **Enhanced community transmission and exposure of health care workers, health care mobilisers and community workers to COVID-19** due to non-adherence to public health guidelines and lack of/or poor management of PPE,

(ii) **Risks to vulnerable Groups:** Vulnerable groups include people with chronic conditions/disabled, poor people, migrants, the elderly and, disadvantaged sub-groups of women, Indigenous Peoples (IPs). They face several risks which include exclusion from consultations, difficulty to access services, potential displacements, etc,

(iii) **Handling of Project and Personal Information** will cover (i) general project information which must be shared with all stakeholders for the smooth running of the project and (ii) handling and storage of Personal data collected in the process of project implementation in COVID 19 response, (iii) misinformation in social media networks related to COVID-19,

(iv) **Disruptions from Construction Activities** will include disruptions of utilities that may be caused by the contractors, temporary disruption of Health Care services as sections of the health facility is cut off for refurbishments/renovation, Occupational Safety and Health (OHS) of the construction workers and impacts of construction activities on patients, staff, and other stakeholders.

1.5.2 Environmental Risks

Environmental risks from project activities are primarily due to:

(i) Environmental degradation from construction waste emanating from renovation/refurbishment/reconstruction, the installation of water tanks and basic sanitation (flush/pour flush to piped sewer system, septic tanks, pit latrines, ventilated improved pit latrines, composting toilets or pit latrines with slabs),

(ii) OHS for anyone working on refurbishment and/or health staff, including accidental contact with infectious or asbestos containing waste/materials and the risk of COVID-19 spreading among health care workers. Poor practices during provision of medical services, blood testing, analysis of samples without proper protective equipment would pose a high risk of infection and possible mortality of healthcare workers,

(iii) Hazardous (including asbestos containing materials (ACM), and medical waste (including infectious materials, liquid effluents, reagents, etc.) generated from health facilities, hospitals, labs, quarantine, and screening posts. Improper handling, managing, transporting, and disposing of these waste streams pose health and safety risks to health care workers, patients and the public in general from infectious materials, COVID-19 infected waste, radiological waste (from x-rays and the like) and other general waste,

(iv) Hazardous and laboratory waste generated from supported laboratories which may include hazardous chemicals, infected samples, obsolete chemicals, etc,

(v) Infectious waste generated from the implementation of COVID 19 response programme, including waste from menstrual health kits, waste from testing kits, masks, etc. (mitigation in ICWMP).

1.6 PPE REQUIREMENTS FOR PROJECT IMPLEMENTATION

Various PPE will be expected to be used in the course of implementation of the ESMF which will include at refurbishment/construction sites and in hospitals. The following sections outline the recommended PPE for these operations.

1.6.1 PPE Requirements for Refurbishing/Construction sites

The following are the PPE Requirements for Refurbishing/Construction sites.

Table 1-2 Construction Sites PPE

No.	PPE	PURPOSE OF THE PPE
1	Safety Helmet or Hard Hat	Protect the head from injury due to falling or flying objects, or due to striking against objects or structures
2	• Safety spectacles • Goggles • Face shields	Eye & face protection
3	Earmuffs	Ear defenders
4	• Gloves • Heavyweight coated glove	Hand protection
5	• Boots • Safety shoes • Footwear • wellingtons or Gum Boots	Foot Protection
6	Hi-Viz clothing*	Distinguishing clothing or reflective devices or otherwise conspicuously visible material when there is regular exposure to danger from moving vehicles
7	Face Masks with filters	Respiratory equipment
8	Work wear (e.g., overalls)	Overall protection
9	Waterproofs if needed	Waterproof clothing and head coverings when working in adverse weather conditions

1.6.2 PPE for COVID-19

The recommended PPE for COVID-19 are outlined in the National PPE guidelines for COVID-19 which have been adapted from the WHO guidelines; “the Rational use of personnel protective clothing (PPE) March (2020)”.

The recommended PPE for COVID-19 for Zimbabwe are outlined in the project’s ICWMP.

1.6.3 PPE for Incinerator Operators

Personal protective equipment (PPE) must be selected to protect against risks specific to incinerator operators. The major risks to these staff are encountered either during direct contact with medical waste or when incinerator operators are exposed to heat or fumes

emitted by the incinerator while burning health care waste. Wearing PPE reduces risk from sharps, germs, exposure to blood and other bodily fluids, splashes from chemicals, inhalation of exhaust, and sparks from the incinerator.

The recommended PPE for incinerator operators for Zimbabwe is outlined in the project's ICWMP.

1.7 IMPLEMENTATION ARRANGEMENTS

CORDAID will continue to serve as the PIE for HSDSP AF-(V). It will manage all WB-GFF funds, remaining as the purchaser of services for the urban RBF and voucher program. It will expand its implementation responsibilities to cover provincial and central hospital quality-focused RBF pilots, Expanded Supply Side Community RBF pilot, and COVID-19 emergency response. The MoHCC PCU will continue to be the national purchaser for RBF services in the 18 rural districts being supported by the HSDSP AF-(V). The Project will continue to engage civil society organizations and use third party verification (e.g., Health Professions Authority) to monitor RBF performance.

Regarding HSDSP AF-(V) interventions, the PIE will work closely with the MoHCC-PCU which will, in turn, coordinate with the HSDSP EOC at national and sub-national levels. The PIE will handle all fiduciary activities including procurement. While the National Pharmaceutical Company of Zimbabwe (NATPHARM) will handle storage and distribution of Pandemic response goods and equipment including those purchased through HSDSP AF-(V), the PIE will monitor and verify that these items reach target facilities and are used for their intended purpose. To this end, it will use a geo-tracking system and pilot the use of block-chain technology. It will also mobilize Provincial Officers, as well as Health Centre Committees which include community representatives from youth groups, women's associations, religious entities, etc. to confirm availability of equipment and supplies and service provision.

The Community Working Group on Health (network of community-based/civil organizations), international NGOs such as CORDAID and development partners also participate in the National RBF Steering Committee and several COVID-19 Response Committees. The Project Implementation Manual will be updated to clarify key stakeholders' (including relevant private sector entities) roles and responsibilities. Additional TA involving the WB Governance, Disaster Risk Management and HNP teams will be provided to improve coordination and governance of HSDSP AF-(V) activities including strengthening public financial management. The Project will also finance regular internal and external financial audits.

HSDSP AF-(V) proposes to finance the following additional technical staff:

(i) a Maternal and Neonatal Health Technical Specialist, and a Reproductive, Adolescent and Family Planning Technical Specialist to support the MOHCC Family Health Department,
(ii) a communications specialist to support RBF, GRM and COVID-19 response-related interventions,
(iii) Operations Research Analyst,
(iv) two regional health specialists to support provincial and central hospital RBF,
(v) two community RBF officers,
(vi) an additional UV Program Assistant, and
(vii) an Environmental Specialist.

In addition, the PIE administrative staff shall be strengthened to include:

(i) a dedicated Accountant/Finance Officer and
(ii) a Procurement and Logistics Officer.

Other positions such as additional specialized safeguards staff to complement MOHCC staffing in implementing its HSDSP AF-(V) response, ESMF and Infection Control and Waste Management Plan (ICWMP) will be added if needed. Implementation arrangements will be extensively reviewed after two years.

The environmental safeguards issues of HSDSP AF-(V) will be managed by a full-time Environmental Specialist (ES) who will be based at the PIE head office and will be supported by Environmental Health Teams in the Provinces and Districts. This ESS will implement the ESMF and ICWMP as part of the PIE. In the Districts/Provinces, there will be Environmental Health Teams, headed by the MoHCC Environmental Health Department and will be consisting of:

- MoHCC - Environmental Health Department,
- MoECTHI - EMA District Officers and ZINWA,
- MOPSLSW - Social Welfare Department,
- MLGPWNH - Public Works Department,
- Local Authorities
- CORDAID.

The Social safeguards issues and the implementation of the GRM, will be handled by the Communications Specialist who will be based at the PIE head office and will be supported by MoHCC head office Health Promotion Department and Public Relations Unit. At province and district level, she will be supported by the Health Promotion Officers. She will be working closely with the Environmental Specialist (Figure 1-1).

The Health Facilities will select sub-projects with the assistance of the District/Provincial Technical Teams. Figure 1-1 depicts the organisational chart indicating the responsibilities of the teams at different levels.

At PIE Head office, the Environmental Specialist and the Communications Specialist will concentrate on the planning, supervision, reporting and support to Provincial and District Technical Teams.

At each Provincial/District office, the Environmental Health Department and the Health Promotion Department and Public Relations Unit will support Provincial/District Project implementation activities and facilitate the communication with the central PIE. They will coordinate all environmental and social Safeguards issues and oversee the implementation of the ESMF and GRM under the oversight of the Environmental Specialists (ES) and the Communications Specialist.

The Provincial/District Technical teams led by the Environmental Health Department, Health Promotion Department and Public Relation Unit will help the Health Facilities in preparing their sub-projects applications to avoid or minimize adverse environmental and social

impacts. The Technical Teams will assist to screen the sub-projects and develop ESMPs for the sub-projects that will require them. If the ESMP is for a construction sub-project, it will be developed together with the Contractor and approved prior to start of works. The ESMP will incorporate the relevant aspects of the WBG Environmental, Health and Safety Guidelines as outlined in Appendix 3 and form part of the bidding documents and be part of the contract for contractors. For screening, they will use the Environmental and Social Screening Form (see Appendix 1) together with information on typical sub-project impacts and mitigation measures in the template ESMPs (Appendix 6).

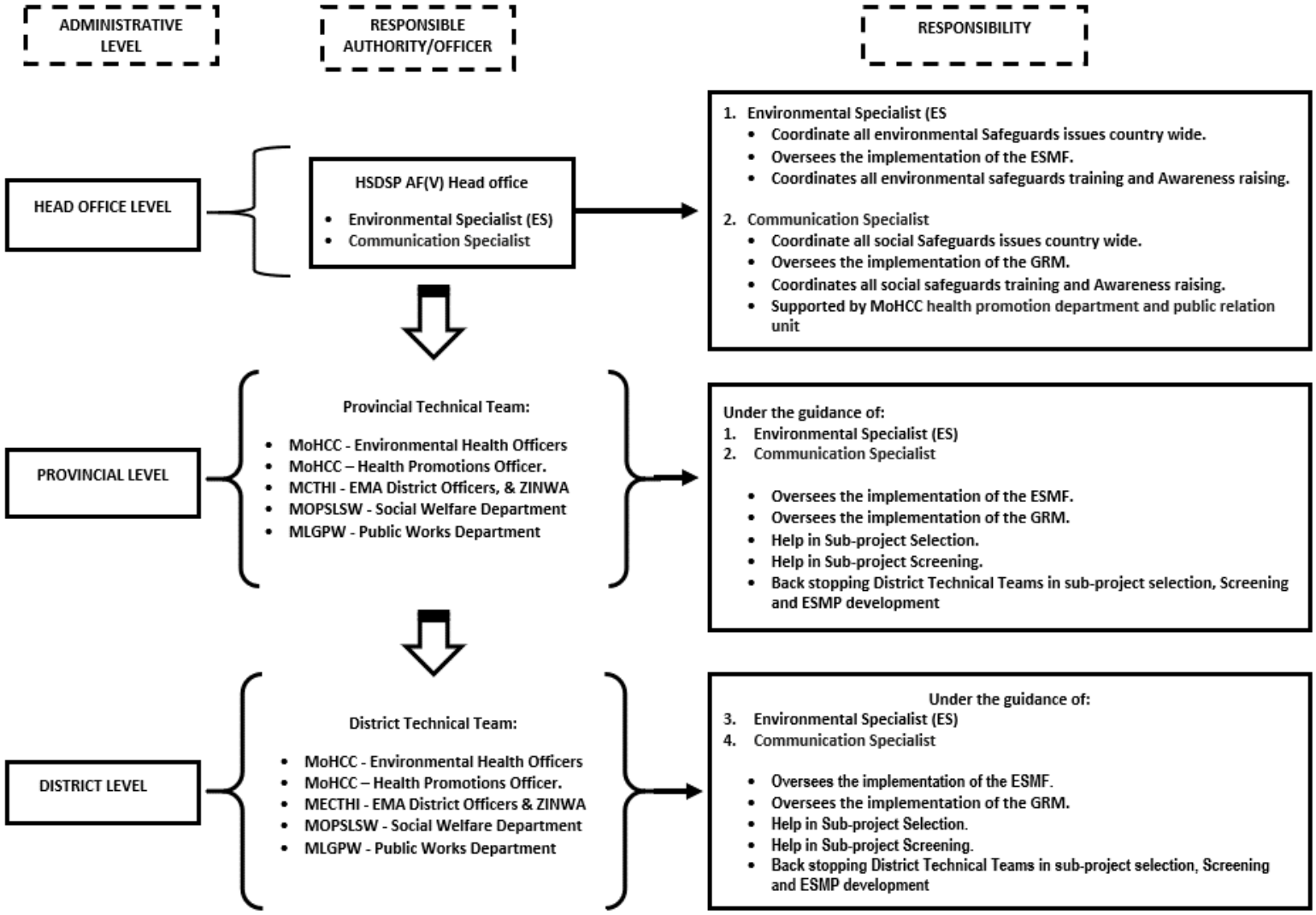

Figure 1-1 Organisational Chart for Safeguards Responsibilities

2. ENVIRONMENTAL AND SOCIAL METHODOLOGY

2.1 REVIEW OF LITERATURE

The primary source for describing institutional, policy and legal frameworks was existing legal instruments (Acts and Regulations) complemented by existing literature both physical and electronic.

Secondary sources of information were obtained through a review of available documents, as well as consultations held with key stakeholders across the Country.

From the literature, all possible envisaged environmental and social impacts were listed and evaluated based on policy and legal requirements. The data on geology and soils, climate, water resources, biodiversity, human and ecosystems were obtained from existing literature, especially from developing partners like the UNDP, World Bank, etc. The following are examples of some of these sources of information:

Table 2-1 Sources of information

No.	REFERENCES
1.0	**UNDP, 2017;** Zimbabwe Human Development Report, Climate Change and Human Development: Towards Building a Climate Resilient Nation, 2017, UNDP, Harare, Zimbabwe **Issues covered**: UNDP has looked into issues which affect pandemic responses and related activities in their book Zimbabwe Human Development Report, Climate Change and Human Development: Towards Building A Climate Resilient Nation (2017), health issue come into play.
2.0	**WB 2009;** Good Practice Note: Asbestos: Occupational and Community Health Issues, World Bank Group, Washington, May 2009 **Issues covered**: The World Bank Group Environmental Health and Safety General Guidelines (2007).
3.0	**Ncube, G and G.M. Gomez,** Remittances in rural Zimbabwe: From Consumption to Investment, in: International Journal of Development and Sustainability, Volume 4.2, p.181-195Trading Economics, Zimbabwe unemployment rate, accessed at: https://tradingeconomics.com/zimbabwe/unemployment-rate **Issues covered**: Ncube et al in remittances in rural Zimbabwe aptly states and shows how unemployment has a bearing on health issues and other downstream activities.
4.0	**GoZ, 2016;** Zimbabwe National Statistics Agency, Government of Zimbabwe. Zimbabwe Demographic and Health Survey, November 2016, accessed at: https://dhsprogram.com/pubs/pdf/FR322/FR322.pdf **Issues covered**: The Government of Zimbabwe journal, Zimbabwe national statistics agency (November 2016) demography and health issues are contrasted, and a direct relationship was shown to occur.
5.0	**Maplecroft, 2018;** Climate Change Vulnerability Index 2018, accessed at https://www.maplecroft.com/solutions/environment-climate-change/ **Issues covered**: Maplecroft in his analysis, of Climate Change Vulnerability Index (2018), looks at the way climate change has affected food security, health, and life expectancy of the general population. He emphasises the need to relate to the continuous change occurring in climate and adapt to it to maintain the health of the population on an acceptable index.
6.0	**WB, 2018;** Zimbabwe, Human Development Indices and Indicators, World Bank, 2018 Statistical Update, accessed at: http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/ZWE.pdf.

No.	REFERENCES
	Issues covered: Finally, the World Bank, Zimbabwe Human Development Indices, and Indicators Statistics (2018) show how development is related to the population and indicators of development are shown in this narrative.

2.2 ANALYSIS OF BASELINE ENVIRONMENTAL DATA

The baseline environmental data was readily available from literature and the internet. This data was compiled with the purpose of describing and evaluating the current environmental status of the Project area, which happens to be national.

The baseline information included environmental information relevant to all Project components, drawing on existing information from Projects in the targeted areas. The description of the baseline environment was based on the bio-physical status of the country covering:

(i) topography,
(ii) geology,
(iii) geomorphology,
(iv) hydrology,
(v) hydrogeology,
(vi) soils,
(vii) climate,
(viii) ecosystem status.

2.3 SITE VISITS AND WORKSHOP DISCUSSION

Because of the current limitations imposed by the COVID-19 Pandemic, full-scale site visits could not be conducted. The strategy that was applied included the following:

- Limited site visits:
  - Mashonaland East, Harare, Bulawayo, Matabeleland South, and Matabeleland North were sampled for site visits,
  - In each province a central hospital, Provincial Hospital, District Hospital, Clinic, COVID designated Hospital, Isolation Centre, etc were visited and staff at different levels interviewed,
  - Also participating ministries and Agencies like Ministry of Local Government and the Environmental Management Agency (EMA) were also visited,
  - As the situation allowed, face to face interviews, completion of Questionnaires and focus group meetings were conducted.
- Several Virtual Zoom Meetings were made with some of the key stakeholders like MoHCC management, EMA Head office, etc,
- All key stakeholders in MoHCC, participating Ministries, and Agencies were surveyed using an electronic questionnaire.

Appendix 5 outlines the stakeholders who were engaged.

2.4 ANALYSIS OF SAFEGUARD POLICES AND REGULATIONS

Projects funded by the World Bank, should fully comply with the World Bank safeguard policies and the Zimbabwe laws and legislation. The relevance of safeguard policies on this Project's four components together with their associated sub-projects was assessed. It became apparent that OP 4.01 Environmental Assessment was triggered because Project activities had physical on-the-ground impacts such as generation of medical waste, refurbishments, and installations of WASH facilities at health centres. The Indigenous Peoples Policy is also triggered because there is a possibility that indigenous communities could be present in or near several areas targeted by Component 4 (COVID response). If their presence is confirmed, the Project will address any risks posed to them and measures put in place to ensure that they receive culturally appropriate benefits.

The environmental risks arise from activities such as support for basic handwashing and sanitation facilities (e.g., septic tanks or pit latrines; ventilated improved pit latrines, composting toilets, or pit latrines with slabs). And from supporting other items like:

(i) IPC self-care kits for quarantined cases,
(ii) PPE and goods for health personnel involved in patient case management,
(iii) medicines and medical supplies, diagnostic reagents including kits for public health facilities.

Thus, the planned minor improvements in water and sanitation will not have any significant environmental impacts, but the enhanced health delivery system will result in the generation of increased volumes of clinical waste. The major issues then become related to the management of infectious healthcare waste and the associated occupational health and safety.

The World Bank Safeguard policies also require compliance to all relevant local, national, and international policies and legal requirements. The relevant national polices and legislation were reviewed in chapter 4. EMA is the competent authority in the approval of safeguards instruments and post-approval monitoring at national level.

3. PROJECT BASELINE INFORMATION

Zimbabwe is endowed with diverse natural resources, which include highlands, forest, and water resources, which accommodate diverse species of flora, fauna, and fish resources. However, these resources are under immense pressure from a complex interaction of several factors which include general development, over abstraction, unsustainable land use and climate change.

The following paragraphs review some of the key country's social, environmental, and natural resources such as demography, economy, nutrition, gender, land ownership, land resources, atmospheric resources, biological resources, and water resources as well as the health-related issue.

The following table (Table 3-1) shows the Distribution of the potential Health Facilities to be funded by HSDSP AF-(V):

Table 3-1 Distribution of Health Facilities to be funded by HSDSP AF-(V)

No.	ACTIVITY	LOCATION
1.	Rural RBF	424 facilities in 18 districts (the districts are found in the 8 rural provinces-2 districts per provinces in the 6 provinces and 3 districts per province in the remaining 2 provinces)
2.	Urban Voucher	34 health facilities in the two big cities (Harare and Bulawayo) and 2 central hospitals
3.	Community RBF	in 4 districts which will be selected from the 18 districts
4.	Hospital quality focused RBF	2 central hospital (which are already under urban voucher) and 4 provincial hospitals (which are among the 424 facilities in the rural RBF).
5.	COVID-19	5 isolation/treatment facilities (for installation of water tank and some minor works, PPE, Ventilators), 104 hospitals (only for provision of PPE), 10 laboratories (GeneXpert Cartridges for PCR test to diagnose COVID-19).

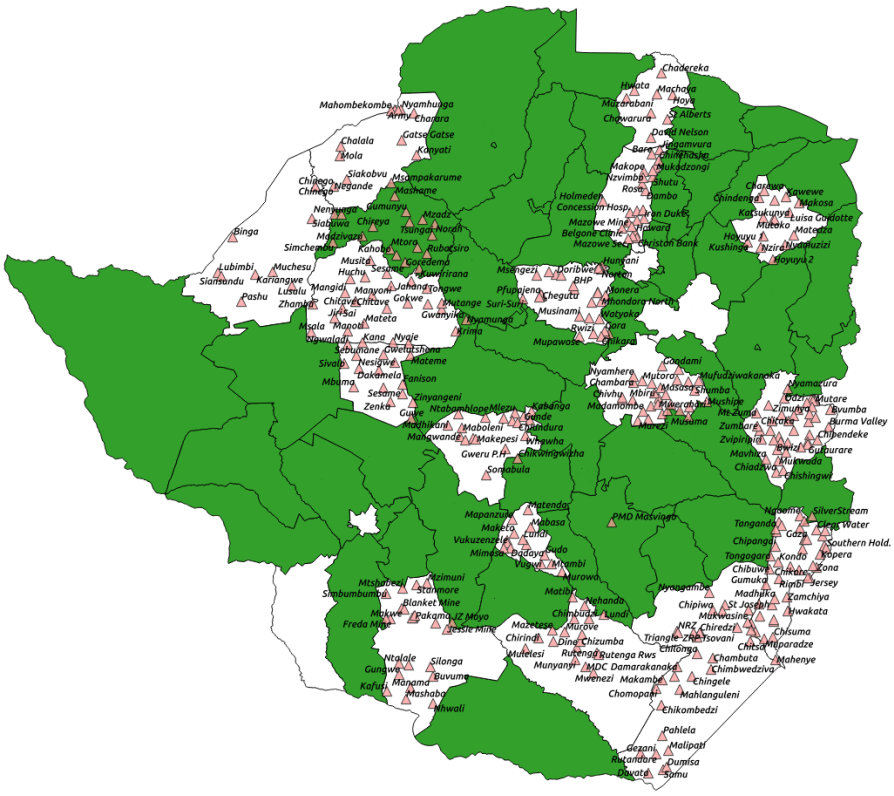

Figure 3-1 Distribution of project health care facilities in the different districts

3.1. SOCIO-ECONOMIC ENVIRONMENT

The following is an outline of the social context within which the programme is being designed. It covers the population and economic settings of the country:

3.1.1 Demography

The population of Zimbabwe has grown during the 20th century in accordance with the model of a developing country with high birth rates and falling death rates, resulting in relatively high population growth rate (around 3% or above in the 1960s and early 1970s). After a spurt in the period 1980-1983 following independence, a decline in birth rates set in. Since 1991, however, there has been a jump in death rates from a low of 10 per 1000 in 1985 to a high of 25 per 1000 in 2002/2003. It has since subsided to just under 22 per 1000 (estimate for 2007) a little below the birth rate of around 27 per 1000. (CIA 2007)

The high death rate is a result of poor medical facilities. This leads to a small natural increase of around 0.5%. Deaths due to HIV/AIDS have reduced due to improved methods of protection. However, the effects of the current pandemic are yet to be quantified.

Based on the 2019 revision of the World Population Prospects, the population of Zimbabwe was estimated by the United Nations at 14,438,802 in 2018. About 38.9% comprised youths under 15, while another 56.9% grouped persons aged between 15 and 65 years. Only around 4.2% of citizens were apparently over 65. Figure 3-2 below illustrates the population pyramid for Zimbabwe for 2017. (UNDESA, 2019)

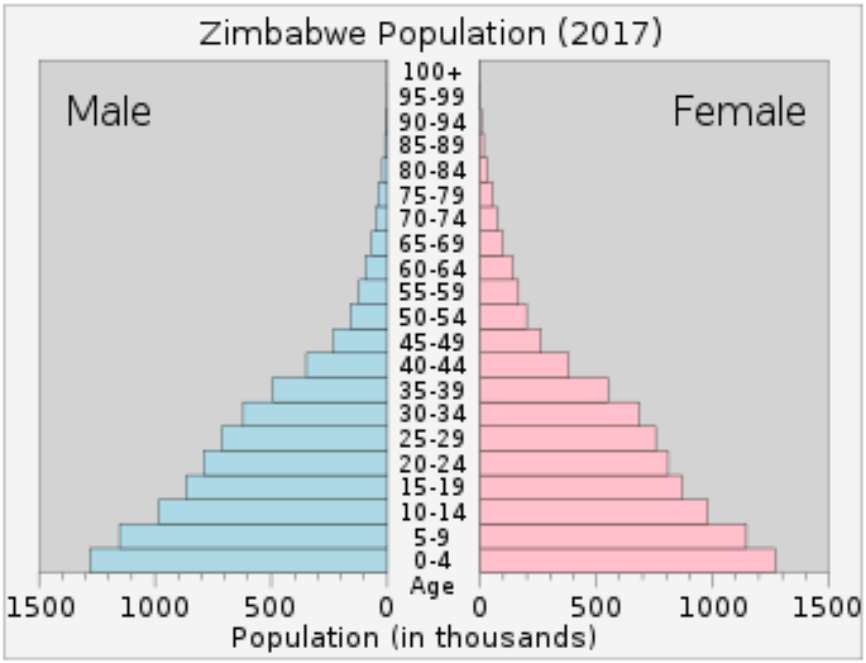

Figure 3-2 Population pyramid of Zimbabwe in 2017 (https://en.wikipedia.org/wiki/Demographics_of_Zimbabwe#cite_note-3)

0-14 years: 38.62% (male 2,681,192 /female 2,736,876)
15-24 years: 20.42% (male 1,403,715 /female 1,461,168)
25-54 years: 32.22% (male 2,286,915 /female 2,234,158)
55-64 years: 4.24% (male 233,021 /female 361,759)
65 years and over: 4.5% (male 255,704 /female 375,860) (2018 est.)

3.1.2 Zimbabwe Economic Outlook and Macroeconomic performance

GDP contracted by 12.8% in 2019 due to poor performance in mining, tourism, and agriculture. Foreign currency and electricity shortages affected mining and tourism. Agriculture shrank about 15.8% due to cyclone Idai in March 2019, prolonged drought, livestock diseases, and currency shortages reducing the availability of inputs. Despite a global mineral price recovery, production in Zimbabwe dropped below 2018 levels. Austerity measures through the Transitional Stabilization Program 2018–20 and attendant monetary reforms constricted economic activity. Any 2020–21 recovery would depend on quick turnaround in the real sector. In the medium term, however, fiscal, and monetary reforms are expected to stabilize the economy and begin to generate positive results.

Following the February 2019 unpegging of the exchange rate from the US dollar and the June 2019 introduction of the new currency—the Zimbabwe dollar —the exchange rate deteriorated from 2.5 Zimbabwe dollars per US dollar in February 2019 to 20 Zimbabwe dollars per US dollar in November 2019. Inflation spiked from single digits in 2018 to more than 200% in November 2019, occasioned largely by the exchange rate movements and by shortages of basic goods, including fuel, foodstuffs, and electricity. The current account deficit, at 2.2% of GDP in 2019, put pressure on urgently needed foreign exchange and made enhancing exports critical. The budget deficit narrowed from 9.9% of GDP in 2017 to 5.6% in 2018 and 6.0% in 2019, mainly due to government measures, which include frozen public sector employment, reduced investment and consumption spending, better revenue mobilization, and restrictions on government borrowing and the issue of government securities. (AfDB, 2020).

Public debt remains above the statutory target of 70% of GDP. In June 2019, external debt constituted 87% of the debt, estimated at $8 billion, of which about $5.9 billion (73.75%) was accumulated arrears. Multilateral institutions are owed $2.6 billion (31.25% of external debt). Bilateral debt amounted to $5.1 billion, with Paris Club creditors owed $3.5 billion and others owed $1.6 billion.

More than 60% of the population falls below the poverty line, while income inequality remains high. Employment opportunities continue to dwindle. About 2 million people in the rural areas were food insecure in April–June 2019—expected to rise to 5.5 million in January–March 2020—with 2.0 million more affected in urban areas. This economic outlook has a serious bearing on the health situation in Zimbabwe as most people will not be able to afford or even access health services (AfDB, 2020).

3.1.3 Human Development

Zimbabwe's Human Development index (HDI) improved from 0.427 in 2000, to 0.522 in 2015, and to 0.535 in 2017 and to 0.563 in 2018 despite the decline in the country's economic performance. This put the country in the medium human development category—positioning it at 150 out of 189 countries and territories.

Between 1990 and 2017, Zimbabwe's life expectancy at birth increased by 3.8 years, mean years of schooling increased by 3.6 years and expected years of schooling increased by 0.5 years. Zimbabwe's GNI per capita decreased by about 29.3% between 1990 and 2017 (UNDP, 2019).

Zimbabwe has amongst the highest HIV prevalence and maternal mortality rates in the region. The country's high mortality and morbidity rates are a result of an under-resourced health delivery system, which is overstretched by the high burden of HIV, tuberculosis (TB), malaria, maternal and childhood illnesses and recently by the COVID-19 pandemic. A decade of worsening economic conditions and rising costs have eroded a once vibrant health system, which now functions largely due to donor assistance.

The health sector has produced notable results in the areas of HIV; TB; malaria; maternal, new-born and child health (MNCH); and family planning/reproductive health (FP/RH). The national response to the HIV epidemic has scaled up prevention and treatment interventions, resulting in an estimated 290,000 lives saved through antiretroviral treatment (ART) since 2009 and a 50% decrease in the number of new HIV infections over the last ten years. The TB treatment success rate increased from 67% in 2006 to 80% in 2015, which meets the National TB program objective and World Health Organization recommendations. Malaria incidence declined by 79%, from 136/1,000 in 2000 to 29/1,000 in 2015. Although the maternal mortality rate declined significantly from 960 deaths per 100,000 live births in 2010/11 to 614 deaths per 100,000 live births in 2014, this rate remains too high by regional standards. The contraceptive prevalence rate increased from 60% in 2006 to 67% in 2014. These are noteworthy gains given the general economic decline and political context and speak to the technical and financial support provided by the donor community. Sustaining these gains will require both continued donor engagement and collaboration with the Ministry of Health and Child Care (MOHCC) to improve the systems and implementation of policies that surround the delivery of health services.

3.1.4 Labour and Employment

With regards to labour and employment, it is estimated that of 7 million economically active persons, approximately 11.3% are broadly unemployed. The largest labour force at 52.3%, are 'own account' workers, being communal, peri-urban and resettlement farmers, working in agro-based businesses (UNDP, 2017).

3.1.5 Crime and Violence

Crime, violence, and conflict are steadily increasing in the Zimbabwean communities due to dwindling livelihoods, increased poverty, and insecurity in general. In general, 35% of women in Zimbabwe experienced physical violence from the age of 15 and, 14% of women reported having experienced sexual violence during their lifetime (ZIMSTAT and ICF International, 2016).

The effects of the current economic meltdown, compounded by the Pandemic Lockdowns have increased the vulnerabilities that exist for women, girls and other marginalized group's exposure to crime and violence especially GBV/SEA. The unravelling of social fabric, as people are exposed to different stresses, can have ample effects on the traditional social protection systems. Where members of households have died or been injured, family-based protection systems may not be functioning anymore; or support through extended families may not be granted anymore, as many households have lost their livelihoods and assets.

3.1.6 Gender Equality and Women's Empowerment

Women in Zimbabwe are under-represented in political decision-making, with their numbers in Parliament at 19%, far below the African Union and SADC target of 50%. Women are also disadvantaged in terms of health, with a high maternal mortality ratio at 960 per 100,000 live births. According to the 2011 Zimbabwe Demographic and Health Survey, 1 in 4 women reported that they had experienced sexual violence, and 1 in 3 women aged 15 to 49 have experienced physical violence since the age 15.

Reducing gender inequality is widely recognised around the world as contributing to a country's food, health, and nutritional security. In Zimbabwe, the statistics for women are much lower than men on socio-economic indicators including secondary and tertiary education enrolment and completion, wage equality, political participation, and literacy. As much as the legal framework exists, the response from both government and civil society is still under resourced, uncoordinated, and inadequate. According to USAID (2018), women have little control over land even when it belongs to them despite their critical role in food production for their households and the country at large. This lack of control to land and other productive resources is not only a major hindrance to women's empowerment, but it makes them vulnerable to poverty and susceptible to ill-health.

The second National Gender Policy (2013- 17) tries to empower women and girls through addressing several underlying causes such as persistent unequal power relations between men and women, boys and girls due to strong patriarchal attitudes, increasing cases of gender based violence, high HIV/AIDS infection rates especially among women and girls, continued high dropout rates for girls from schools, high poverty levels particularly amongst women, limited participation and representation of women in decision-making processes at all levels, inadequate enforcement of laws, and huge disparities in access and control over resources by the majority of women.

3.1.7 Social Structure

Bantu-speaking ethnic groups make up 98% of the population of Zimbabwe. The most populous people are the Shona, comprising 70% of the population. The Ndebele are the second most populous with 20% of the population.

The Ndebele descended from Zulu migrations in the 19th century and together with other tribes with whom they intermarried on their way.

Other Bantu ethnic groups make up the third largest with 2 to 5%: These are the Venda, Tonga, Shangaan, Kalanga, Sotho, Ndau, Nambya, Tswana, Xhosa and Lozi.

Minority ethnic groups include white Zimbabweans, who make up less than 1% of the total population. White Zimbabweans are mostly of British origin, but there are also Afrikaner, Greek, Portuguese, French, and Dutch communities.

3.1.8 Social Protection

Generally, Zimbabwe's social protection system has been adversely affected by declining incomes, loss of livelihoods, and lack of economic opportunities. This has led to a general disintegration of social fabric with increasing levels of diseases such as HIV/AIDS.

Households and communities have different opportunities at their disposal which they can use to deal with shocks and stressors they face. These include the following:

- Formal social support – from government and NGOs,
- Bonding Social Capital– support from other community members both relatives and nonrelatives,
- Bridging Social capital - support from relatives and non-relatives leaving outside the community within Zimbabwe,
- Informal safety net – support from churches and community groups,
- Remittances – from outside Zimbabwe.

Generally, the wellbeing of the general Zimbabwean has been sturdily decreasing as shown by the Food Consumption Patterns in Figure 3-3 below (FNC, 2019).

- The proportion of households which were consuming an acceptable diet decreased from 55% in 2018 to 47% (2019),
- The proportion of households consuming poor diets increased to 24% from 20% reported in 2018. This points towards deteriorating household food access,
- Most of the households (53%) were consuming borderline to poor diets which is an 8 percentage points increase from the 45% in 2018 indicative of deteriorating food security status among the rural households.

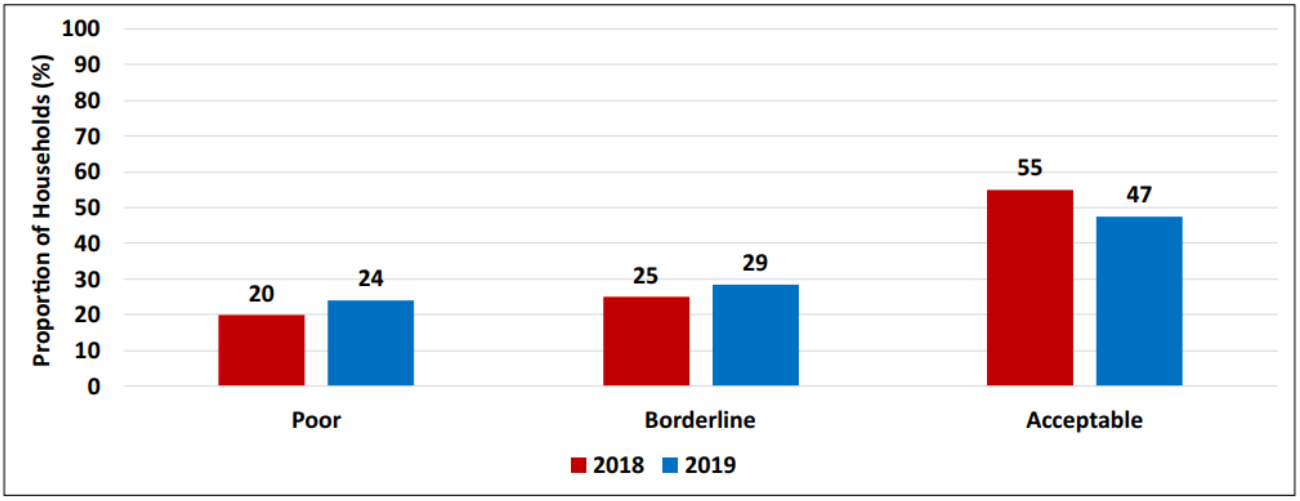

Figure 3-3 Food Consumption Patterns (FNC, 2019)

3.1.9 Coping strategies

Table 3-2 outlines the Livelihood Coping Strategies that a household can employ. Zimbabwe as a Nation scored 5.7 on the Coping Capacity Index, indicating 'lack of coping capacity' (UNDP, 2017). Reasons cited for this are infrastructure and institutional challenges, including limited physical connectivity, access to health care, and communication. In addition, corruption, government ineffectiveness and poor governance exacerbate the already fragile situation where socio-economic challenges are linked to multi-dimensional poverty, deprivation, and inequality (UNDP, 2017)

Table 3-2 Household Livelihood Coping Strategies (FNC, 2019)

CATEGORY	COPING STRATEGIES
Stress	• Borrowing money, spending savings, selling assets, and selling more livestock than usual.
Crisis	• Selling productive assets directly reducing future productivity, including human capital formation. • Withdrawing children from school • Reducing non-food expenditure.
Emergency	• Selling of one's land thus affecting future productivity, more difficult to reverse /dramatic in nature. • Begging of food. • Selling the last breeding stock to buy food.

Figure 3-4 below shows the households engaging in livelihood coping strategies by province (FNC, 2019). Manicaland (16%), Mashonaland Central (15%) and Matabeleland South (15%) had the highest proportion of households engaging in emergency coping strategies. Whilst the highest proportion of households employing stress strategies were in Manicaland (28%).

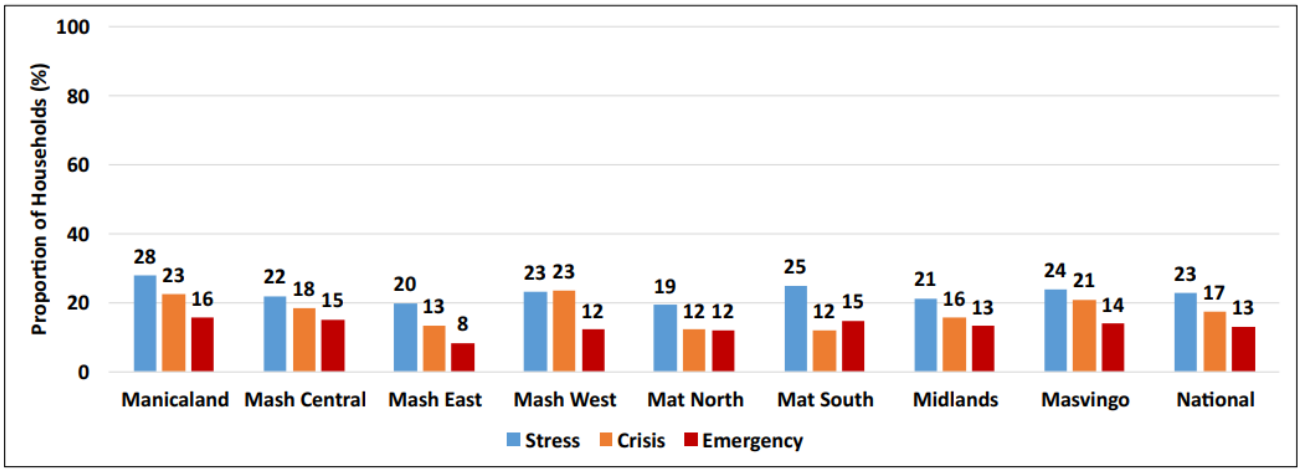

Figure 3-4 Households Engaging in Livelihood Coping Strategies by Province (FNC, 2019)

3.1.10 Health

At Independence in 1980, Zimbabwe adopted the Primary Health Care (PHC) Approach in line with the Alma Ata Declaration of 1978. The implementation of the PHC approach resulted in decentralization of health service provision from central level (cities and towns) to administrative wards at district level in the rural communities. Four tiers for health service delivery were established as follows:

- Quaternary Level: Central Teaching Hospitals with specialist medical services in the capital city Harare, the second largest city Bulawayo and in Chitungwiza,
- Tertiary Level: Provincial Hospitals with ambulatory and inpatient specialist services in the eight rural provinces of Zimbabwe,
- Secondary Level: District Hospitals with emergency, ambulatory, and inpatient services in the sixty-two districts of Zimbabwe,
- Primary Level: Rural Health Centres with primary care services in the 220 wards of Zimbabwe.

This decentralization was associated with a significant improvement of most health indicators in the 1980s and early 1990s.

3.1.10.1 Experiences with Health Services

Generally, the disease burden has been increasing in Zimbabwe as shown by figure 3-5 below. There was an increase in the proportion of households with at least one member living with HIV/AIDS from 12% (2018) 27% (2019), (FNC, 2019).

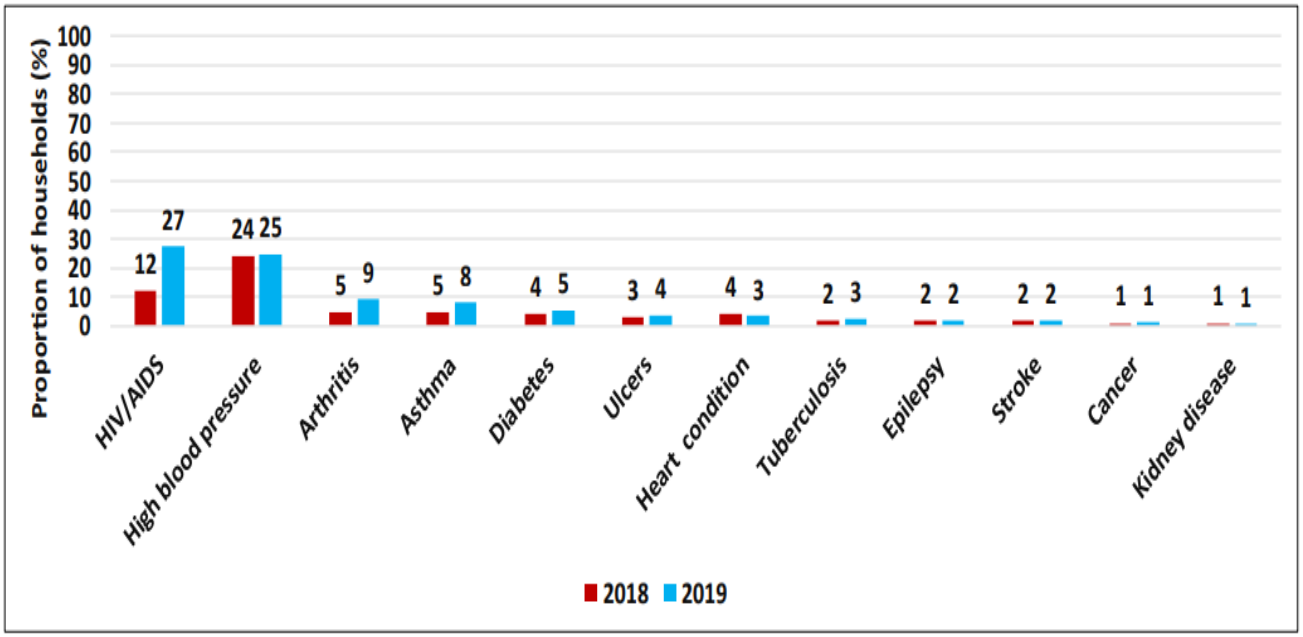

Figure 3-5 Households with at Least One Member Living with a Chronic Condition (FNC, 2019)

The presence of a member living with a chronic condition is likely to increase the household's financial burden. However even if one can afford healthcare it is not a guarantee that residents will be able to get the medical attention they need. It may also depend on whether qualified staff, functioning equipment, and sufficient drugs are available.

Figure 3-6 below illustrates the ease with which households with at least one member Living with a chronic condition (FNC, 2019) could access treatment services. Approximately a third (27.9%) of households consisting of at least one member living with a chronic condition, reported failure to accessing treatment services. Failure to accessing treatment services for chronic health conditions was high in Manicaland (37.9%).

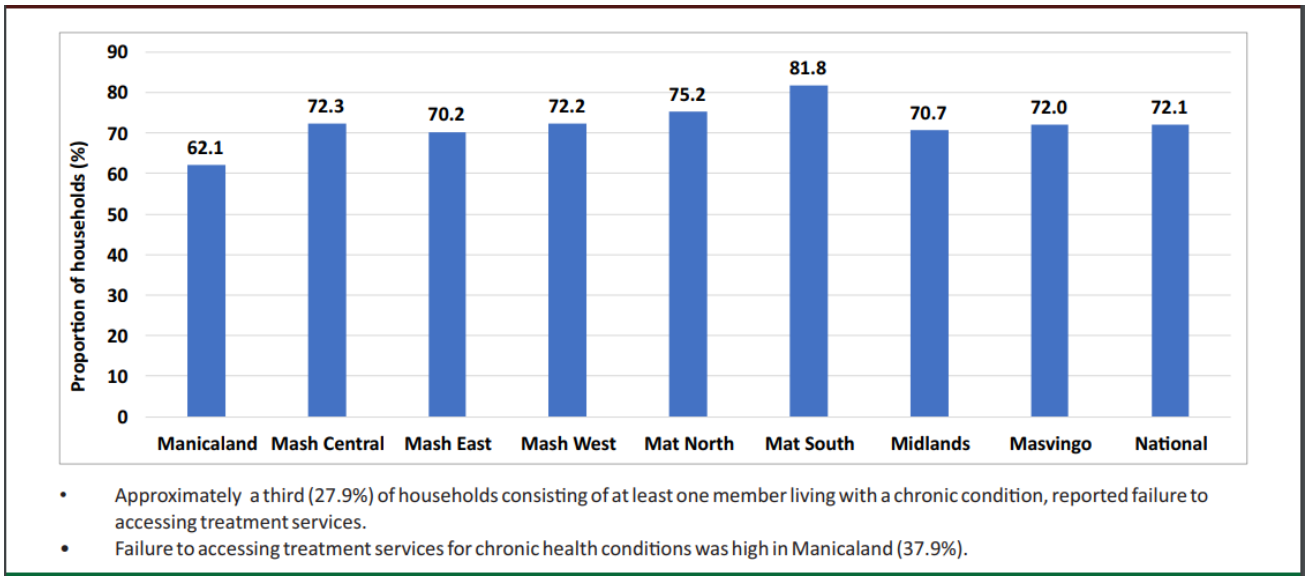

Figure 3-6 Access to Treatment Services among Households with at Least One member Living with a Chronic Condition (FNC, 2019).

In a similar study, Isbell T and Krönke M. (2017) investigated how easy or difficult it was to obtain needed medical care. Of the 59% who had contact with a public hospital or clinic during the year preceding the survey, 54% said it was “easy” or “very easy,” while 46% describe it as “difficult” or “very difficult” (Figure 3-7).

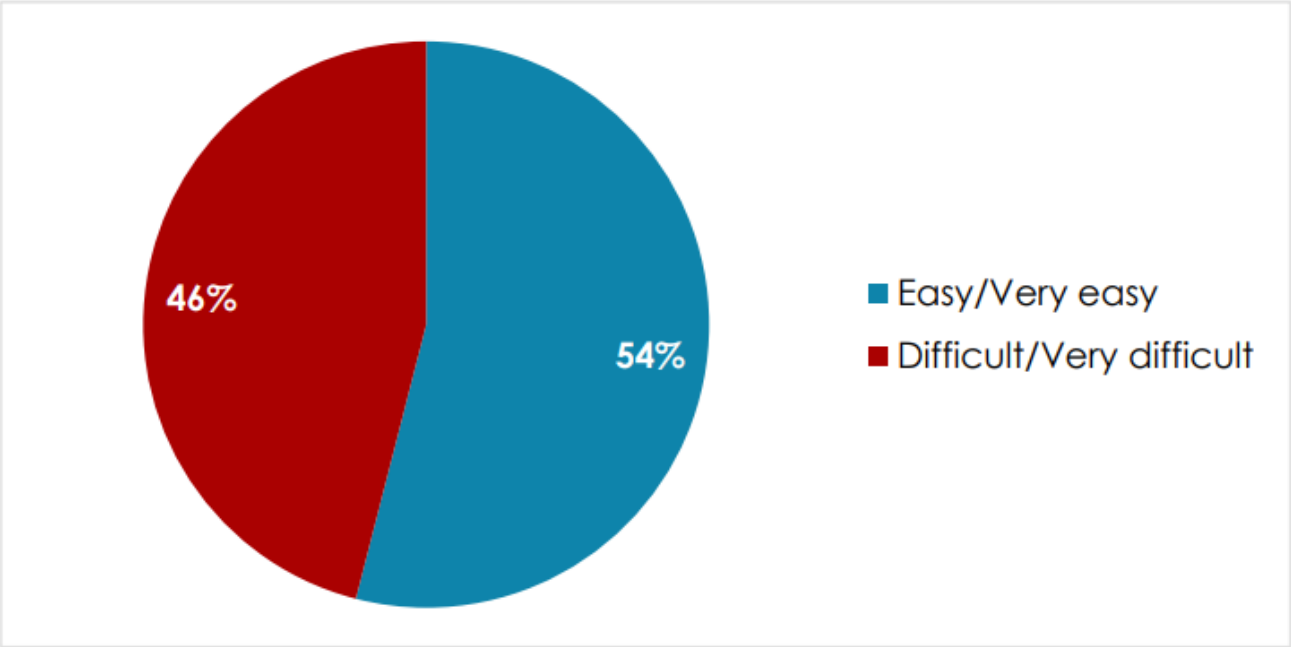

Figure 3-7 Easy or difficult to obtain medical treatment - Zimbabwe - 2017 (Isbell T. and Krönke M, 2017)

Isbell T. and Krönke M, 2017 also found out that more rural (58%) than urban (45%) people found it easy to access health services, and those with no formal education (67%) are more likely than their more educated counterparts to find it easy to obtain care. However poor Zimbabweans struggle significantly more to obtain medical care than wealthier citizens.

The Cholera Crisis of 2017 highlighted Zimbabwe’s shortcomings in the Basic Health Care Delivery System. Access to health care is particularly difficult in urban areas, which were the epicentres of the cholera outbreak and now the epicentres of the COVID-19 pandemic.

3.1.10.2 General Service Availability

General Service availability refers to the physical presence of health service delivery components within the country. The general service availability index is computed as a composite of health infrastructure, health workforce, and service utilization indicators computed relative to a benchmark.

The general service availability index score for Zimbabwe was 42% in 2015. (Figure 3-8) The health infrastructure domain score was highest at 69% while the lowest was 22% for service utilization. On average, both health workforce density and service utilization were below half of the expected target values. There was a clear need for more trained health professionals which would most likely result in an increase in health service utilization (MOHCC, 2015)

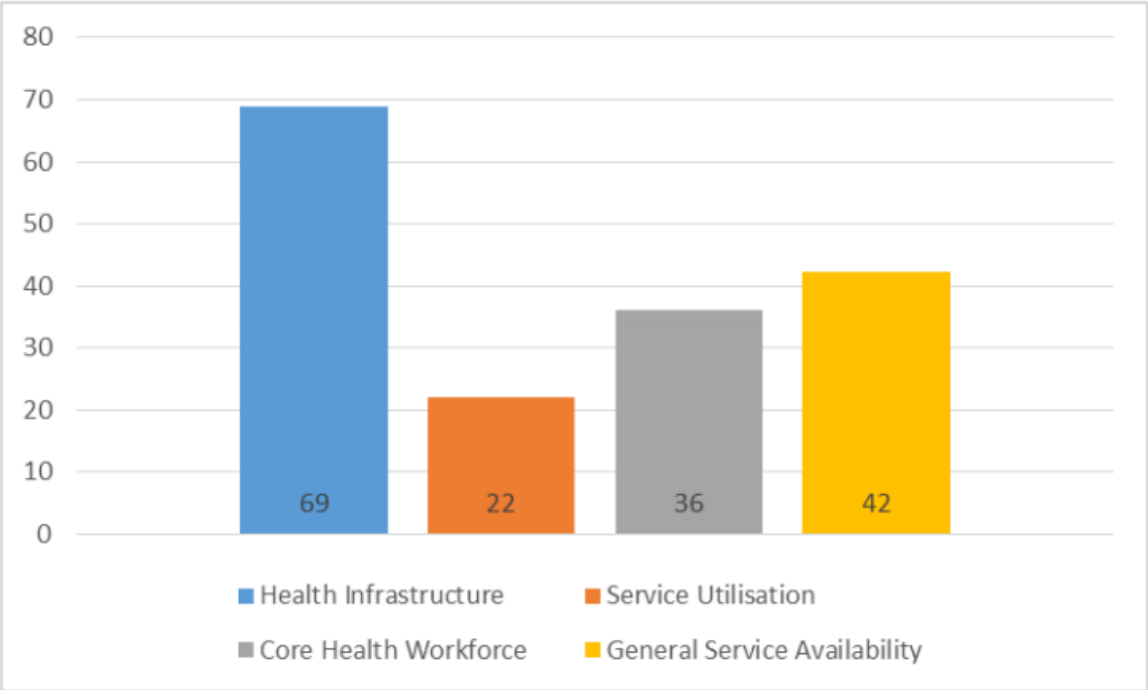

Figure 3-8 General Service Availability index and domain scores for Zimbabwe (MOHCC, 2015)

3.1.10.3 General Service Readiness

General Service readiness refers to the capacity of health facilities to provide general health services. It measures the availability of infrastructure, equipment and supplies necessary to provide services within the following five domains: basic amenities, basic equipment, standard precautions, diagnostic testing, and essential medicines. The general service readiness index is a composite score summarizing information from the five domains.

Figure 3-9 below shows that the general service readiness index score was 78%. Urban locations had a higher overall readiness score compared to rural locations. There was not much variation on basic equipment scores between rural and urban locations (69% rural vs 66%) urban. Diagnostics were the lowest at 69%.

Figure 3-9 General Service readiness index and domain scores nationally, Zimbabwe (MOHCC, 2015)

3.1.10.4 General Readiness for COVID-19 Response

a) Quarantine Centres

Over 24 quarantine centres in all the 10 provinces

b) Isolation Hospitals

46 isolation hospitals in all 10 provinces in various states of readiness some are accepting patients, others are being renovated to suit purpose.

It should be noted that most of these facilities did not have capacities to handle COVID-19 infections.

Government of Zimbabwe has come up with various remedial measures to ensure compliancy, in line with the current WHO Guidance on COVID-19 covering "healthcare facilities", "waste management", "hazardous materials management", and "construction and decommissioning". (The WHO Guidance on COVID-19 complies with the WBG Environment, Health and Safety (EHS) Guidelines)

3.1.11 Nutrition

The Government of Zimbabwe recognizes that adequate nutrition is a prerequisite for human growth and development, as it plays an important role in one's physical and intellectual development, and consequentially work productivity.

Since 76% of the rural households are considered poor and 23% extremely poor, on average, households are spending over half of their income on food and 33% suffer from food deprivation (ZimVAC, 2017).

While households used fewer and less extreme coping strategies in 2017 than in previous years, there was a decrease in households consuming an acceptable diet and an increase in households consuming a poor diet, as defined by the food consumption score. Overall, 10% of rural households experienced severe hunger in 2017, based on the household hunger score (ZimVAC, 2017, USAID, 2018).

The underlying causes of malnutrition include food insecurity, gender inequality, poor hygiene practices and lack of safe water and sanitation. Stunting levels among children under five improved from 32% in 2010–2011 to 27% in 2015, which is considered high according to WHO/UNICEF (ZIMSTAT and ICF 2016; WHO/UNICEF 2017). Stunting levels vary geographically from 19% in Bulawayo province to 31% in Matabeleland South and are higher in rural areas (29%) than urban areas (22 percent). Differences in stunting levels can also be seen according to maternal education and wealth levels—25% of children whose mothers have secondary education are stunted, while the prevalence rises to 45% of children whose mothers had no formal education. Similarly, 17% of children in the highest wealth quintile are stunted, while 33% of children in the lowest wealth quintile are stunted (ZIMSTAT and ICF 2016). 37% of children 6–59 months are anaemic, a substantial improvement from 2010–11 when over half of children suffered from anaemia. Anaemia prevalence varies regionally, from 29% in Masvingo to 40% in Manicaland (ZIMSTAT and ICF 2016).

3.1.12 Disadvantaged / Vulnerable Individuals and Groups

The health delivery system must be able to cater even for the most disadvantaged and vulnerable individuals, households, and other groups in the communities. Figure 3-10 shows the household vulnerability by province.

Matabeleland South had the highest proportion of households with at least an orphaned child (22%) and Matabeleland North (18%). Manicaland and Midlands provinces had the highest proportion of physically/mentally challenged members (6%), whilst Manicaland, Mashonaland West and Midlands had the highest proportion of chronically ill people (4%).

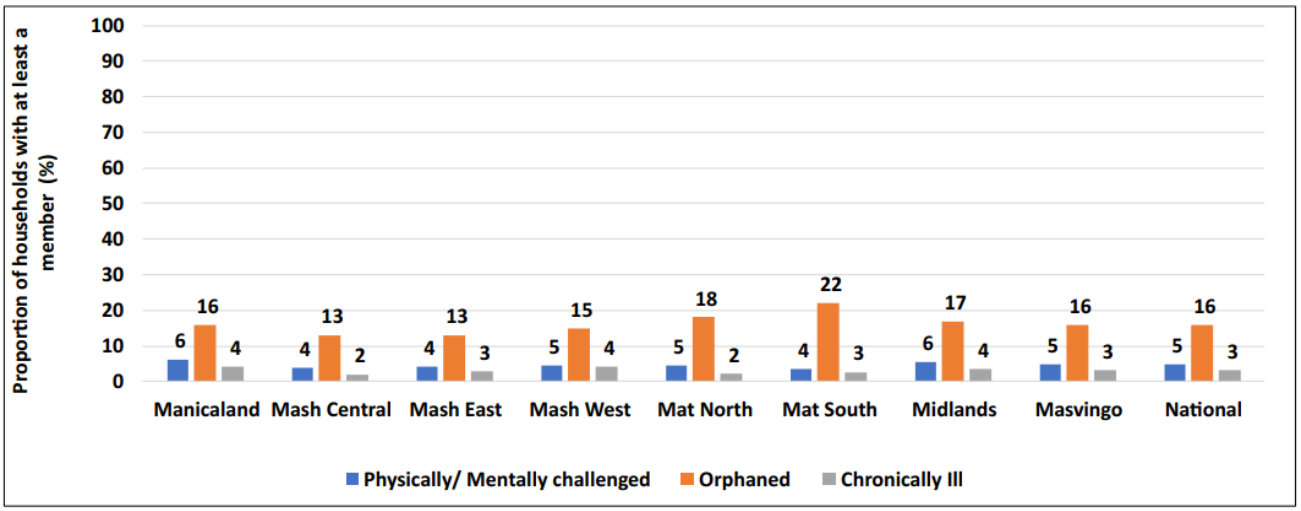

Figure 3-10 Household Vulnerability Attributes (FNC, 2019)

3.1.13 Sex and Age of the Rural Household Head

Generally rural households have an average size of 5.4 and a mode of 5 persons in a household, of which 65.8% are male headed and 34.2% are female headed, (ZimVAC 2018). The average age of the household head is 49.3 years, and most members of the households are aged 18-59 years, suggesting that the rural population is relatively young.

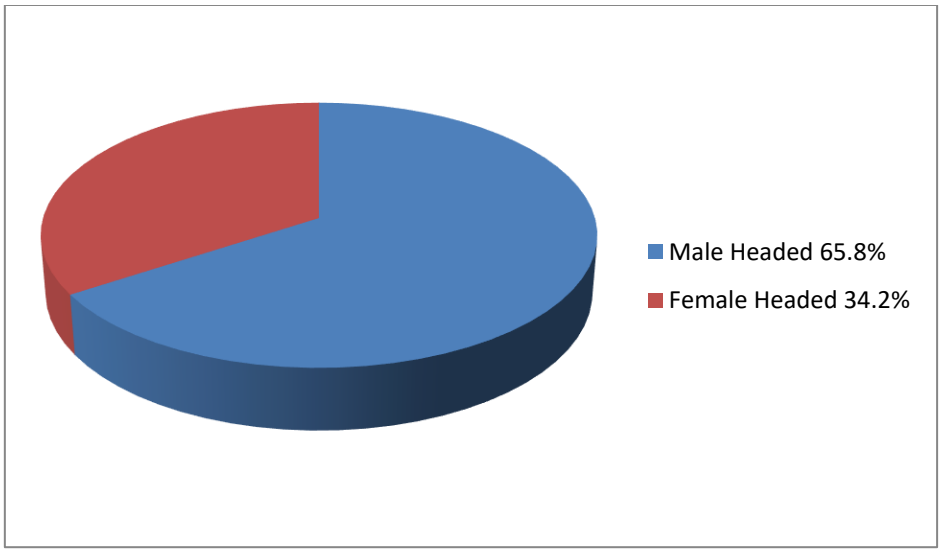

Figure 3-11 Percentage Head of Families

3.1.14 Water, Sanitation and Hygiene (Wash)

3.1.14.1 Water

Improved water incorporates water sources from safely managed, basic and limited water services. Access to improved drinking water has remained constant over the past three years, 2017 (73%), 2018 (72%) and 2019 (72%). (Figure 3-12)

28% of households continue to utilize unimproved water sources for their drinking water.

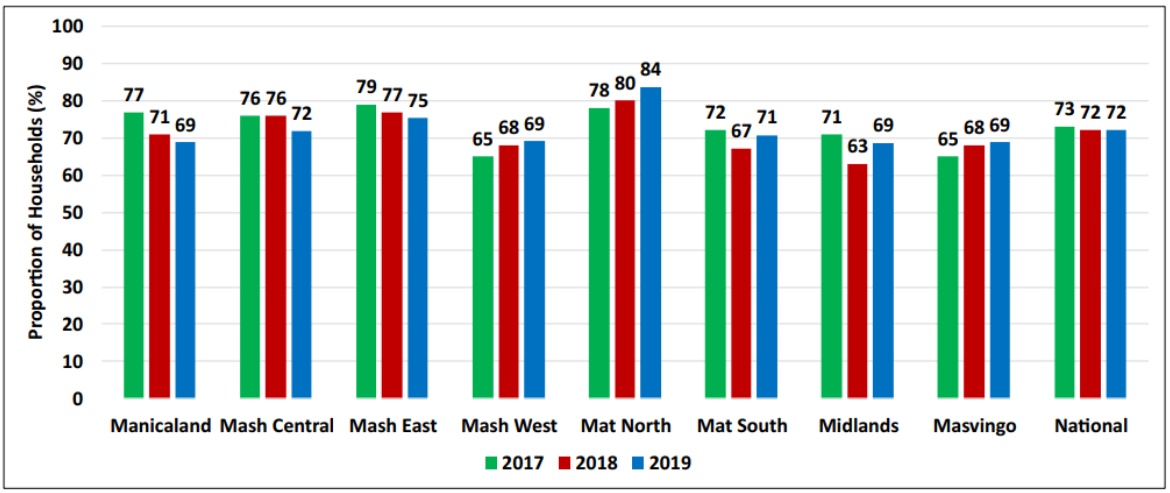

Figure 3-12 Access to Improved Water (FNC, 2019)

3.1.14.2 Sanitation

The proportion of households which have access to basic sanitation services is 45%, and Mashonaland Central has the highest proportion of households (20%) using unimproved sanitation services (FNC, 2019).

Open defecation is practiced by 33% of households nationally, with the highest proportion being in Matabeleland North (60%).

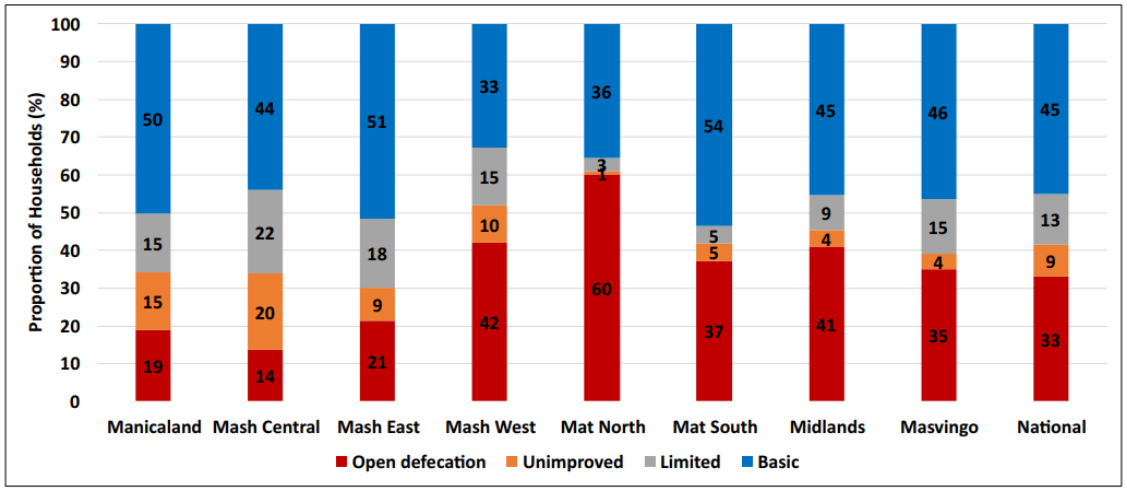

Figure 3-13 Household Sanitation Services (FNC, 2019)

3.1.14.3 Hygiene

Handwashing facilities may be fixed or mobile and include a sink with tap water, buckets with taps, tippy taps, and jugs or basins designated for hand washing. Soap includes bar soap, liquid soap, powdered detergents, and soapy water but does not include sand, soil, ash, and other handwashing agents.

The most observed critical times for handwashing were after using the toilet and before eating food (87%); followed by before handling food (71.5%).

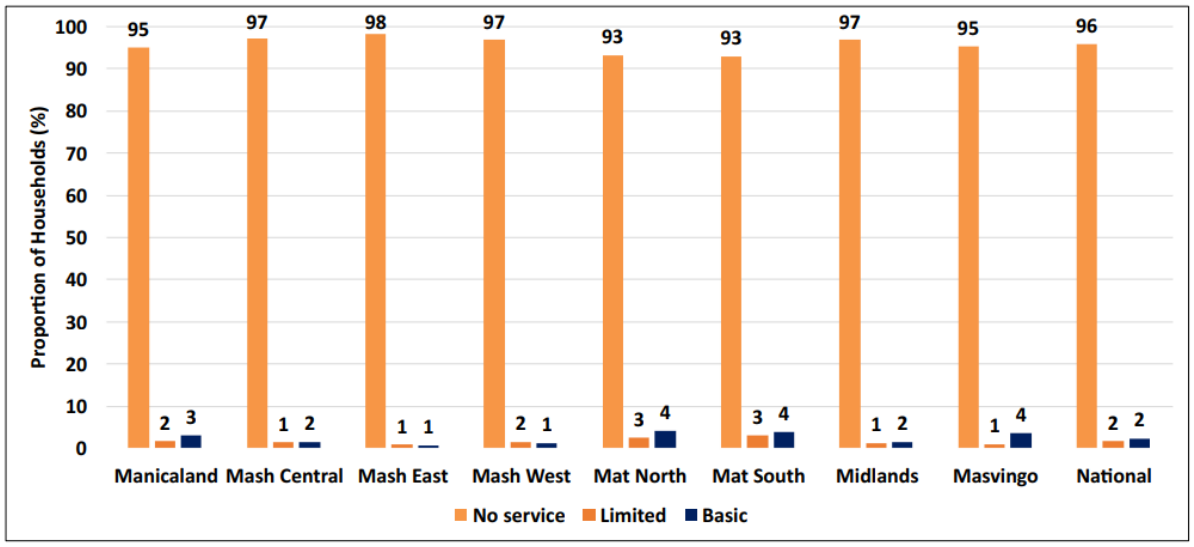

Figure 3-14 Availability of Hygiene Services (FNC, 2019)

Nationally 98% of households do not have basic hygiene services. The presence of hygiene services at the toilet has been proven to increase the likelihood of washing hands immediately after toilet use.

3.2 BIOPHYSICAL ENVIRONMENT

3.2.1 Topography

Zimbabwe is a landlocked country in southern Africa lying well within the tropics. Much of the country is high plateau with the higher central plateau (high veldt) forming a watershed between the Zambezi and Limpopo River systems. The extensive high plateau drops northwards to the Zambezi valley where the border with Zambia is and similarly drops southwards to the Limpopo valley and the border with South Africa. The Limpopo and the lower Zambezi valleys are broad and relatively flat plains. The eastern end of the watershed terminates in a north-south mountain spine, called the Eastern Highlands.

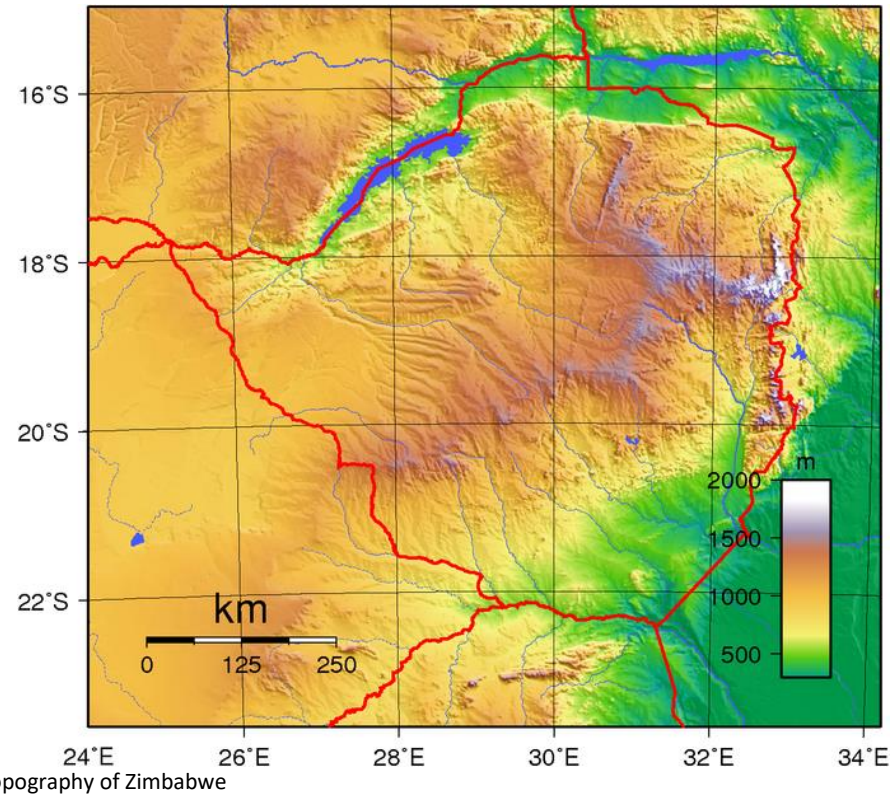

Figure 3-15 Topography of Zimbabwe

About 75% of the country is semi-arid, with low and sporadic rainfall, which makes it prone to unpredictable droughts. Land use varies from intensive cropping to extensive cattle ranching, subsistence and small-scale agriculture, wildlife production, and mineral extraction. Approximately 60% of the country's 14.9 million people live in rural areas.

About 49% of the total land area is under forests and woodlands while 27% is cultivated. The former contains a wide range of fauna and flora that includes 4,440 species of plants, 270 mammals, and 532 bird species. Biodiversity is found in all the country's land categories-namely state, communal and private lands.

The country's ecosystems are formally protected under six categories of protected areas as follows: 11 national parks, 6 gazetted forests, 14 botanical reserves, 3 botanical gardens, 16 safari areas and 15 recreational parks and sanctuaries. National parks and gazette forests constitute 13% and 3% of the country's land area, respectively.

The country is mostly savannah, although the moist and mountainous eastern highlands support areas of tropical evergreen and hardwood forests. Trees found in these Eastern Highlands include teak, mahogany, enormous specimens of strangling fig, big leaf, white stinkwood, chirinda stinkwood, knobthorn and many others. In the low-lying part of the country fever trees, mopane, combretum and baobabs abound. Much of the country is covered by miombo woodland, dominated by bracgystegia species and other. Among the numerous flowers and shrubs are hibiscus, flame lily, snake lily, spider lily, leonotus, cassia, tree wisteria and dombeya.

3.2.2 Climate

The climate of Zimbabwe is tropical, although altitude and relief greatly affect both temperature and rainfall. There is a dry season, including a short cold season during the period May to September when the whole country has little rain. The rainy season is typically a time of heavy rainfall from November to March. The summer rainy season lasts from November to March. It is followed by a transitional season, during which both rainfall and temperatures decrease. The cool, dry season follows, lasting from mid-May to mid-August. Finally, there is the warm, dry season, which lasts until the onset of the rains.

The whole country is influenced by the Intertropical Convergence Zone during January. In years when it is poorly defined, there is below average rainfall and a likelihood of serious drought in the country (as happened in 1983 and 1992). When it is well-defined then rainfall is average or well above average, as in 1981 and 1985.

Box 1

The country is divided into five Natural Regions with varying rainfall. The potential project sites will fall into different regions and will thus exhibit different climates.

Table 3-3 Agro-ecological zones of Zimbabwe and the recommended farming systems in each zone

Natural Region	Area (km^{-2})	Rainfall ($mm\ yr^{-1}$)	Farming system
I	7 000	>1 000	Specialized and diversified farming
II	58 600	750 – 1 000	Intensive farming
III	72 900	650 - 800	Semi-intensive farming
IV	147 800	450 - 650	Semi-extensive farming
V	104 400	<450	Extensive farming

(Vincent and Thomas, 1960).

The five main natural regions are according to differences in effective rainfall (Figure 4-2; Table 4-1). Rainfall patterns and crop production progressively deteriorate from Region I to V (Vincent and Thomas, 1960).

Annual rainfall is highest in Natural region I which covers approximately 2% of the land area. It is a specialized and diversified farming region with plantation forestry, fruit, and intensive livestock production. Tea, coffee, and macadamia nuts are grown in frost-free areas. Natural region II covering 15% of the land area, receives lower rainfall than region I, nevertheless it is suitable for intensive farming based on crops or livestock production.

Natural region III is a semi-intensive farming region covering 19% of Zimbabwe. Although rainfall in this region is moderate in total amount, severe mid-season dry spells make it marginal for maize, tobacco, and cotton, or for enterprises based on crop production alone. The farming systems are therefore based on both livestock (assisted by the production of fodder crops) and cash crops.

Natural region IV is a semi-extensive farming region covering about 38% of Zimbabwe. Rainfall is low and periodic seasonal droughts and severe dry spells during the rainy season are common. Crop production is therefore risky except in certain very favourable localities, where limited drought resistant crops are grown as a side-line. The farming is based on livestock and drought resistant fodder crops.

Natural region V is an extensive farming region covering about 27% of Zimbabwe. Rainfall in this region is too low and erratic for the reliable production of even drought resistant fodder and grain crops, and farming is based on grazing natural pasture. Extensive cattle or game ranching is the only sound farming system for this region.

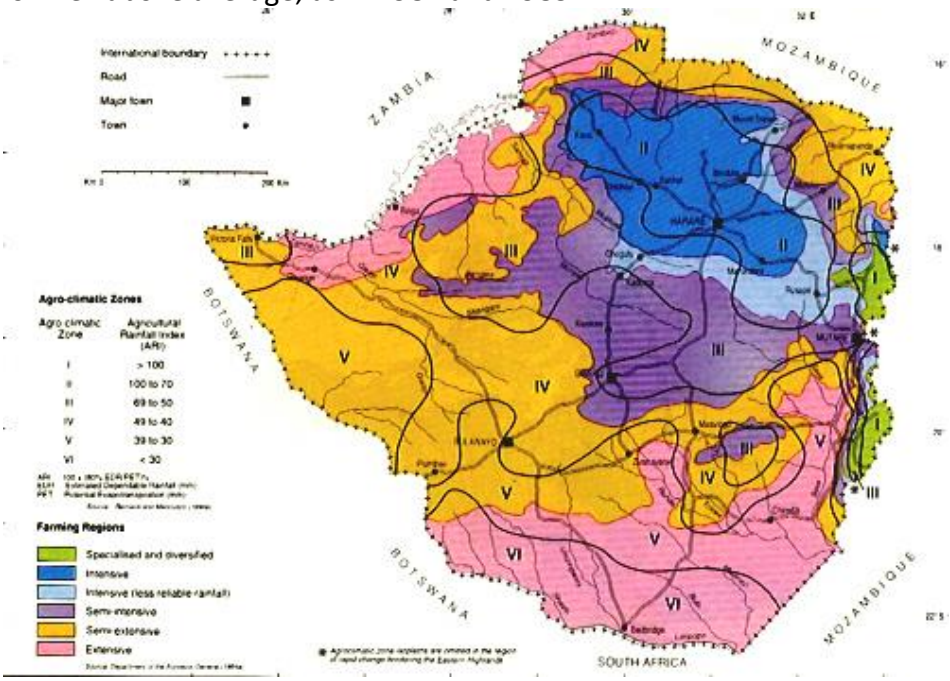

Figure 3-16 Zimbabwe Natural Regions

3.2.3 Climate Change

Zimbabwe is dealing with significant climate change. Global Climate Models (GCM) indicate that most of Southern Africa, including Zimbabwe, is likely to experience higher temperatures (2-4^{0}C higher than the 1961-1990 baseline) in the coming decades, but the picture for rainfall is less clear. While average annual rainfall appears to have changed little over the last 50 years, adverse weather conditions have been increasing with droughts and floods having become more frequent and severe and the onset of the rains less dependable. Zimbabwe ranks 9 out of 16 countries on the Climate Change Vulnerability Index (CCVI).

Climate models predict that Zimbabwe's climate will be warmer than the 1961-1990 baseline with warming rates of 0.5-2^{O}C by 2030.20 The climate change predictions for Zimbabwe are that the country will become hotter and drier, with an increase in violent storms. Floods are thereby the most frequent and dangerous hazard for the country, mostly hitting the northern and south-eastern lowlands (along the path of cyclones). The El Nino phenomenon has had ample impacts in the past, an estimated 4.1 million people in Zimbabwe experienced food insecurity in 2016 due to the phenomenon.

3.2.4 Geology

The geology of Zimbabwe in southern Africa is centred on the Zimbabwe Craton, a core of Archean basement composed in the main of granitoids, schist and gneisses. It also incorporates greenstone belts comprising mafic, ultramafic and felsic volcanic which are associated with epiclastic sediments and iron formations. The craton is overlain in the north, northwest and east by Proterozoic and Phanerozoic sedimentary basins whilst to the northwest are the rocks of the Magondi Supergroup. Northwards is the Zambezi Belt and to the east the Mozambique Belt. South of the Zimbabwe Craton is the Kaapval Craton separated from it by the Limpopo Mobile Belt, a zone of deformation and metamorphism reflecting geological events from Archean to Mesoproterozoic times. The Zimbabwe Craton is intruded by an elongate ultramafic/mafic igneous complex known as the Great Dyke which runs for more than 500 km along an SSW/NNE oriented graben. It consists of peridotites, pyroxenites, norites and bands of chromitite (Wilson, 1979; Cahen et al, 1984).

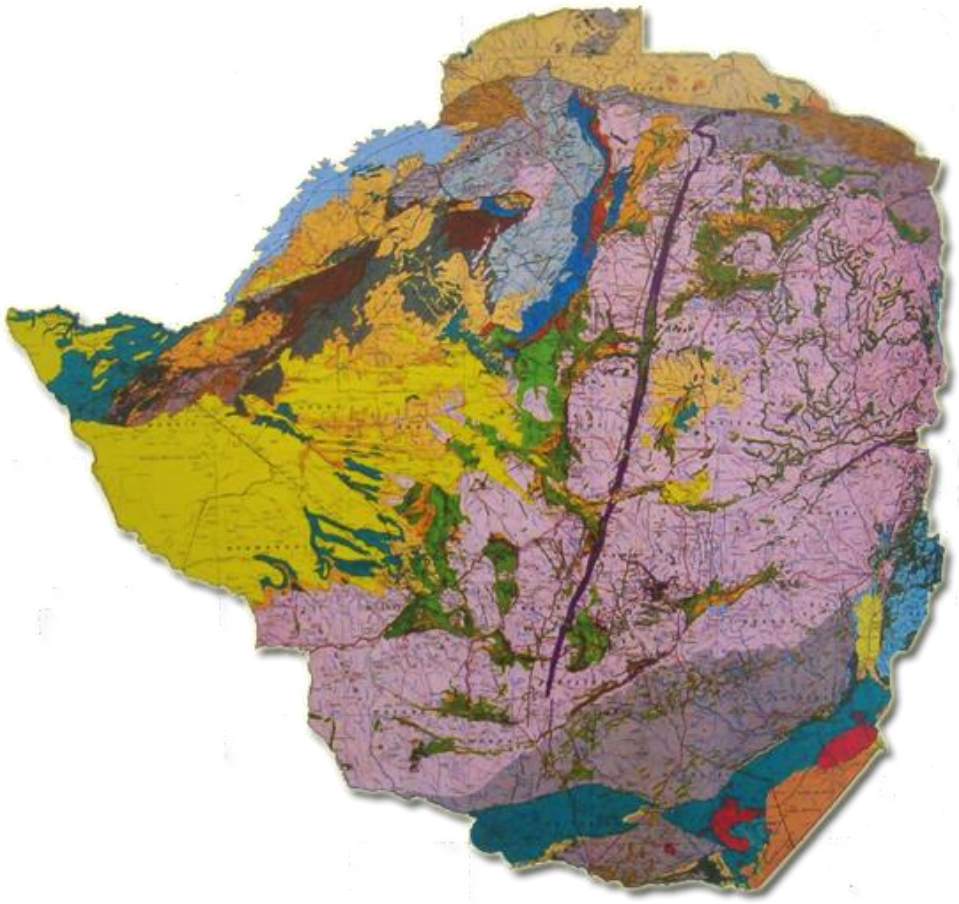

Figure 3-17 Geological map

3.2.5 Hydrology

The country is divided into six drainage basins. The largest are the Zambezi and the Limpopo. Western parts of Matabeleland connect to the Okavango inland drainage basin through the Nata River. Most of the southern Mashonaland and adjacent parts of Masvingo drain through the Save River into the Indian Ocean. Two smaller drainage basins cover parts of Manicaland and drain into the Indian Ocean through Mozambique. These are the Pungwe River to the north and the Buzi River to the south.

3.2.6 Flora and Fauna

The wildlife of Zimbabwe is mostly located in remote or rugged terrain in the national parks and private wildlife ranches; it is spread over the landscapes of miombo woodlands and thorny acacia or kopje. In the Rural areas the wildlife populations are drastically reduced due to the presence of large human populations. Natural vegetation varies with soil-type and hence influenced by geology to a certain extent. Other factors influencing vegetation type include climate, drainage conditions, altitude, and topography.

The prominent wild fauna members which inhabit this landscape include Hippopotamus, buffalo, elephant, leopard, lion, Rhinoceros, Baboon, Okapi, Giraffe, Kudu, Sable, Zebra, Warthog, Porcupine, Badger, Otter, Hare, and many more. In all, there are around 350 species of mammal.

Snakes and lizards abound. The largest lizard, the water monitor, is found in many rivers, as are several species of crocodile. More than 500 species of birds like the Ant-thrush, Barbet, Bee-eater, Bishop bird, Bulbul, Bush-warbler, Guinea fowl, Emerald cuckoo, Grouse, Gray lourie, and Pheasant. Not forgetting the Insect kingdom.

3.2.7 Road Network

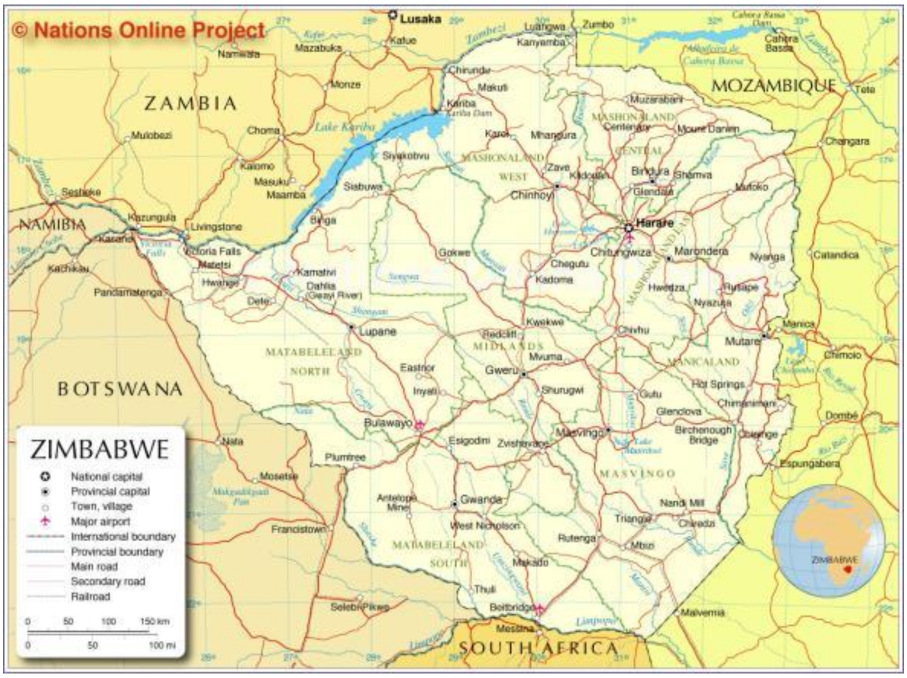

Figure 3-18 Zimbabwe Road network

About 5% of the road network in Zimbabwe is classified as primary roads forming the major links to all major destinations within the country and outside. Some 14% of the network is classified as secondary roads that link the main economic centres within the country, enabling internal movement of people and goods. The primary and secondary roads are collectively referred to as the trunk road system; they carry over 70% of the vehicular traffic (measured in vehicle kilometres) and they are managed by the Department of Roads (DoR). A little more than 70% of the network is made up of tertiary feeder and access roads that link rural areas to the secondary road network. These are managed by the District Development Fund (DDF) and by the District Councils (DC).

The tertiary access roads, together with the unclassified tracks, typically with traffic volumes below 50 vehicles per day, provide for the intra-rural access movements. They link rural communities to social economic amenities, such as schools, health centres, and markets, and enable government services to reach rural areas. These will be important in the implementation of the projects both for being rehabilitated themselves and access to other Project sites.

Figure 3-19 An example of a rural dust road

3.3 HEALTH CARE WASTE SITUATION

Generally, in Zimbabwe the issue of Health Care Waste is out of control and the responsible agencies currently do not have both financial and human resources to adequately respond to it. Although MoHCC has institutionalised HCWM in the Health Care delivery system, the enabling environment for its efficient implementation is lacking. Further, MoHCC has embarked on a nationwide HCWM related training and hopes to continue in this drive not only to train staff but also to raise the awareness of the public.

Poor waste management is one of the major challenges facing Health Care institutions. Some do not even have prescribed medical waste disposal methods. The medical waste is at times indiscriminately disposed and given less attention creating an immense threat to public health. Medical waste management still has inadequacies from segregation at source to the final disposal with some medical waste finding its way to the municipal dumpsite. Most incinerators at health care facilities are not operating efficiently and thus not treating the waste at all. Currently most of the HCWM facilities are old and broken down and the first step would be to bring them to some working condition. At the health care facilities, the following applies:

3.3.1 Waste Segregation

In most health care facilities, the waste that is religiously separated from the rest are needles which are placed in designated yellow containers or two litre plastic medicine bottles. The other waste may be segregated into infectious (pink) and non-infectious (black) lined bins (Figure 3-20). However, on transportation to the treatment facilities the waste tends to be remixed. In some instances, the infectious and non-infectious waste is not being segregated and its handling posed serious challenges as it is not labelled, either on the bin or the plastic lining.

Figure 3-20 Segregation of waste in a hospital

3.3.2 Temporary storage

Before treatment waste is stored under secure conditions (Figure 3-21). In most health centres there are no appropriate temporary storage facilities and where they are available, they are not being used.

Figure 3-21 Temporary storage for waste

In small clinics where the sharps must be transported elsewhere for incineration, they are stored in one of the rooms in the clinic until transport is found. At smaller centres which use lined pits, the sharps containers were being recycled. The needles are tipped into the pit and the yellow sharps box retained and reused.

3.3.3 Treatment and Disposal of Waste

(i) General Waste

Figure 3-22 Municipal Landfill and Open pit disposal

In urban areas general waste is land filled (Figure 3-22) and in rural areas it is burnt in open pits. The large local Authorities like Harare have landfills. The challenge they are facing is the proper running of the landfill sites as resources are scarce and the proper maintenance procedures are being left undone. There are no official disposal sites in the rural areas and each centre must manage its own waste.

(ii) Infectious Waste

Figure 3-23 The incinerator and a lined pit at a hospital

Infectious waste is incinerated or disposed of in lined pits (Figure 3-23). Most of the hospitals have incinerators which are mostly not working due to lack of maintenance and age. All Government hospital incinerators do not operate to the recommended minimum temperature of 1200^{o}C. In smaller facilities, the organic infectious waste is disposed of in the lined pits (Figure 3-23).

Incineration residues such as fly ash, bottom ash and liquid effluents from flue gas cleaning are not being managed properly at most facilities. The ash is at times dumped in open pits and poses a danger of polluting the environment as they may contain Persistent Organic Pollutants (POPs) due to incomplete combustion in the old incinerators.

(iii) Sharps

Figure 3-24 Concrete lined pit for sharps disposal at a Clinic

In hospitals and clinics with incinerators, sharps are incinerated but in smaller Health Care Facilities sharps are disposed of in lined pits (Figure 3-24). The pits should be secure, and their base must be above the water table. In some instances, the pits were not lined.

3.3.4 Sanitation

Sanitation is either by pit latrines, septic tank system, or water borne sewage reticulation as in large urban areas. Most of the Health Care Facilities do not have adequate facilities for the patients and visitors that come to the institutions. The available facilities are either old and dilapidated or broken down altogether. The main problem is lack of maintenance. The existing infrastructure is old and needs replacement in most cases.

3.3.5 Home Based Care

Home based care waste is disposed of in lined pits in Rural Areas (Figure 3-25)

Figure 3-25 Concrete lined pit for Home based Health Care Waste

3.3.6 Health Care Waste Handling Licenses

There are various licenses required for handling and managing health care waste, which include Incinerator Emission Licences, Hazardous Waste Transportation Licences, and Waste Enterprise Licence. All these licenses are explained in section 4.4, table 4-4. The licence fees have been summarised in Section 11.3 table 11-2.

4. ZIMBABWE LEGAL FRAMEWORK & WB SAFEGUARDS POLICIES

4.1 INTRODUCTION

In this chapter, relevant Zimbabwe regulations and policies are assessed that guide the environmental and social assessment for the HSDSP AF-(V) activities, as well as relevant World Bank Environmental and Social Standards and international conventions. The objective is to ensure that project activities and implementation processes are consistent with local laws and policies and World Bank Safeguards Policies, and to point out possible gaps in local legislation in view of full compliance with World Bank standards. The proposed HSDSP AF-(V) project will be subject to a number of these pieces of legislation. The following paragraphs highlight some selected policies and laws which are applicable in the planning and implementation of a health delivery project, and they include:

- Public Health Act (CAP15:17),
- Mental Health Act,
- Labour Act (cap28:01),
- Water Act 20:24,
- Environmental Management Act 2027,
- Impact Assessment Policy 1997,
- Environmental Management (Effluent and Solid Waste Disposal) Regulation SI6 of 2007,
- Environmental Management (Hazardous Substances, Pesticides and Other Toxic Substances) Regulation (SI12 of 2007),
- Hazardous Waste Regulation (SI 10 of 2007),
- Local Government Act of 1997.

4.2 THE CONSTITUTION OF ZIMBABWE

Stipulates that Zimbabwe will adopt policies designed to protect and enhance the natural and cultural environment of Zimbabwe for the benefit of both present and future generations and shall endeavour to ensure all citizens a sound and safe environment adequate for their health and well-being.

Section 73. Environmental rights

The Constitution outlines the Environmental rights and stipulates that everyone has the right to:

a) an environment that is not harmful to their health or well-being and
b) have the environment protected for the benefit of present and future generations, through reasonable legislative and other measures that—
   i. prevent pollution and ecological degradation,
   ii. promote conservation and
   iii. secure ecologically sustainable development and use of natural resources while promoting justifiable economic and social development.

It further states that the State must take reasonable legislative and other measures, within the limits of the resources available to it, to achieve the progressive realisation of the rights set out in this section.

Section 76. Right to health care

The Constitution of Zimbabwe also articulated health as one of the principles of Equality and Justice in the Constitution of The Republic of Zimbabwe. Health, according to the Constitution is important and the Zimbabwean government shall adopt policies aimed at ensuring the highest attainable standard of physical and mental health for its citizens, including policies designed to –

1. Every citizen and permanent resident of Zimbabwe has the right to have access to basic health-care services, including reproductive health-care services.
2. Every person living with a chronic illness has the right to have access to basic healthcare services for the illness.
3. No person may be refused emergency medical treatment in any health-care institution.
4. The State must take reasonable legislative and other measures, within the limits of the resources available to it, to achieve the progressive realisation of the rights set out in this section.

The Zimbabwean Government further committed itself to give equitable access to standard quality health service to all its citizens without discrimination on religious, political, colour, income levels, disabilities, geographical location, and wealth. The Government has set a good baseline for the implementation of good health care delivery for all. The activities of the project will ultimately feed into the National Development Strategy 1 (2021-2025) and the 2030 National Vision.

Since HSDSP AF-(V) activities may have a potential to disrupt the wellbeing of the environment and thus affect the people's health, its implementation must adopt approaches that will conform to the requirement of the Constitution.

4.3 OVERVIEW OF RELEVANT ZIMBABWE POLICES AND PLANS

Over the years, the Government of Zimbabwe pursued national policies that had a major bearing on social protection outcomes. These policies sought to ensure that the poor and vulnerable are protected through a network of social transfer programmes. They ranged from policies on labour market participation; price controls; user fee exemptions for accessing basic social services; coordination of humanitarian assistance and regulating the work of non-governmental organizations (NGOs), among others. They also included policies that target specific vulnerable groups that included the Gender Policy; Orphan Care Policy; HIV/AIDS Policy Framework; National Action Plan for Orphans and other Vulnerable Children; agricultural inputs support; and others.

Table 4-1 Relevant Policies

No.	RELEVANT POLICIES	INTERPRETATION	RELEVANCE TO HSDSP AF (V)
1.	**National Environmental Policy, 1998**	Zimbabwe's National Environmental Policy is linked to its overall development policy and plans. Although this development model has been considered relatively successful, much of the country's natural resource base is being threatened by human activities. In many respects, Zimbabwe is one of the leading countries in Africa in terms of work on the environment. This for example is reflected in the economically important wildlife sector. Although some species are endangered due to habitat destruction, the country's rich wildlife resources have been professionally managed. Several innovations, which have promoted sustainable utilisation of wildlife, could serve as a model for other countries. Environmentally sensitive areas have been designed and gazetted as national parks and forest reserves. There is no lack of environmental legislation per se, but existing regulations are fragmented and difficult to enforce. This is also reflected in the large number of ministries responsible for enforcing environmental legislation. The National Response Conference to the Rio Earth Summit convened in Harare in late 1992 presented an elaborate set of future priorities. Building upon the National Conservation Strategy of 1987, the government is planning to develop a comprehensive Action Plan for the Environment.	The policy goes a long way in aiding in health issues. The environment determines the health issues i.e., air water and dust play a major role to name but a few.
2.	**Environmental Impact Assessment Policy Guidelines, (1997)**	The purpose of these guidelines is to ensure that environmental consequences of any development proposals (mining, housing, industry etc.) are understood and adequately considered in the planning process of the project. The guidelines provide check lists to be considered during project development. The goals of this EIA Policy include: • To encourage environmentally responsible investment and development in Zimbabwe. • To maintain the long-term ability of natural resources to support human, plant and animal life. • To conserve a broad diversity of plants, animals, and ecosystems; and the natural processes that they depend upon. • To conserve the social, historical, and cultural values of people and their communities. The EIA Policy has 9 principles which guide it including:	This policy is relevant to HSDSP AF (V) since guidelines if adhered to will produce a desired outcome which will enhance the health of the population

No.	RELEVANT POLICIES	INTERPRETATION	RELEVANCE TO HSDSP AF (V)
		• Sustainability for future generations is the cornerstone of environmental management. • EIA must enhance development by contributing to its environmental sustainability, not inhibit it. • EIA is a means for project planning, not just evaluation. • Project impacts must be monitored throughout the life of the development. The EIA Policy requires that EIA studies be undertaken for all new projects prescribed for EIA. Projects involving construction on a large scale` are prescribed for EIA. Further, the EIA Policy also requires that the public particularly the stakeholders be consulted during the EIA study. These guidelines will be useful in subproject screening, ESIAs and ESMP as they forecast potential risks and impacts to look out to for different sectors	
3.	**Water policy**	Water use in Zimbabwe is governed by the Water Act of 1998. The Act is one of the key outcomes of the water sector reforms which took place in the mid-90s. However, traditional systems also exist whereby traditional leaders hold power to declare water protection areas especially where quality is an issue. This policy designates Urban Local Authorities (ULAs or Urban Councils) and Rural District Councils (RDCs) as Water Services Authorities who have a duty to ensure efficient, affordable, and sustainable access to water services are provided for all their current and potential consumers The responsibility at operational level of providing water supply and sanitation services may be delegated by a ULA or RDC to a designated Water Services Provider which is a legal entity capable of carrying out water supply and sanitation services on behalf of the ULA or RDC. Service Authorities will have the power and authority (through a revision of the Urban Councils Act and the Rural District Councils Act), to enter into contractual agreements with Service Providers if they do not supply the services themselves. Service Providers will be legal entities (public, private, or mixed) that have the capacity to provide water supply and sanitation services to Service Authorities The Constitution further provides, in Section 77 that every person has a right to safe, clean, and potable water, and sufficient food (Food Security, Quality and Safety). These human rights are related to peoples' health as it not possible to divorce the living conditions of people from their health risks and status. This great national health strategy is indeed subordinate to these constitutional provisions and the State has the	Water is inextricably related to health of the population and to harness the health of the population, responsible use of water must be done. This policy is pertinent and relevant to HSDSP AF-(V)

No.	RELEVANT POLICIES	INTERPRETATION	RELEVANCE TO HSDSP AF (V)
		responsibility to create a conducive environment in which it is possible for all people in Zimbabwe to access basic health services whenever they need them.	
4.	**Zimbabwe National Sanitation and Hygiene Policy (Draft)**	The policy aims to create an open defecation free Zimbabwe by 2030 in line with the Sustainable Development Goals. To achieve this, the demand-led Sanitation Focused Participatory Health and Hygiene Education (SafPHHE) has been adopted and is being implemented in the 45 UNICEF-supported rural districts in the country. The Government, of Zimbabwe with support from UNICEF and other partners, has approved a new gender-sensitive Sanitation and Hygiene Policy. The policy aims to create an open defecation free Zimbabwe by 2030 in line with the Sustainable Development Goals in place. To achieve this, the demand-led Sanitation Focused Participatory Health and Hygiene Education (SafPHHE) has been adopted.	Particularly useful with regards to HSDSP AF (V) sanitation is the central item in health-related issues and consequently if executed correctly a healthy population ensues.
5.	**Environmental Health Public Policy (Draft)**	Environmental health is a fundamental public health approach that affects the whole population and provides a foundation for modern living. Neglect of this service has resulted in an increase in diseases associated with environmental factors such as TB. The policy creates the legal framework for the protection of public health in Zimbabwe for this purpose provides for powers of the administration to regulate and control slaughter of animals, food production and handling, food and water supply, animal diseases and other related issues.	Relevant to HSDSP AF (V) the public must be protected at all costs and this policy makes it imperative to take care of the public environs
6.	**Food Security and Nutrition Policy**	The Government of Zimbabwe is fully committed to strengthening national capacity in food and nutrition security through primarily reinforcement and supporting local communities' capacity for food and nutrition security. The country is geared on ensuring that food security occurs because as a country the Policy in place will go a long way in food production. A health population is thus assured.	Without food security the health of the population is compromised. The policy is relevant to the HSDSP AF (V).

No.	RELEVANT POLICIES	INTERPRETATION	RELEVANCE TO HSDSP AF (V)
7.	**National Infection Prevention and Control Policy**	The Zimbabwe Infection Control and Prevention (ZIPCOP) project will work to support the Ministry of Health and Child Care (MOHCC) in improving infection control practices in health care facilities nationwide to prevent the transmission of infectious diseases, including TB, among patients and staff. The policy largely focuses on: • Development and implementation of infection control plans. • Curriculum development, training, and development of IEC materials • Provide and adapt Infection Control tools that MSH has used internationally. • Capacity building to improve leadership, governance, and management structures • Development of the National IPC policy, strategic plan, guidelines, and protocols	Health and the citizens go hand in glove; hence this is relevant to HSDSP AF (V)

Table 4-2 Relevant Operational Manuals, Procedures and Guidelines

No.	RELEVANT OPERATIONAL MANUALS, PROCEDURES AND GUIDELINES	INTERPRETATION	RELEVANCE TO HSDSP AF (V)
1.	**Environmental Health Standard Operating Procedures**	Environmental Health Safe Operating Procedures (SOPs) should be implemented to ensure safe working procedures for staff have been identified and assessed. Standard Operating Procedures (SOPs) are a required supplement to the Laboratory and Research Safety Plan to reduce the risks involved in working with hazardous materials or performing other potentially hazardous operations in the laboratory. In all working environments, these standards must be maintained and adhered to. The guidelines go a long way in ensuring that environmental health standards are adhered to.	According to HSDSP AF (v) if the procedures of the environmental health standard operating procedures are adhered to then the health of the population can be safeguarded.
2.	**BVIP Manual**	The Blair toilet has been used in both rural and semi-rural Zimbabwe to ensure that waste is correctly managed and does not end up in the rivers, dams, and weirs. The "Blair" is popular because it doubles as a washroom and the square spiral structure has become the most popular amenity in rural areas. The Blair is easy to construct and a manual to assist in the process is available. This means that the initial cost is extremely low, but a range of moveable upgradeable structures can be built on top of the pit. Various methods of recycling the organic and constructional components of this unit are also possible. Various manuals related to this model and the construction of the standard BVIP are also available.	Relevant to HSDSP AF (V). Health population because a hygienic Blair system results in a super spreader system of diseases.
3.	**National Health Strategy**	The vision of the Zimbabwe Ministry of Health and Child Care is to have the highest possible level of health quality of life for all its citizens. To achieve this Government has placed several acts and SI s in place. This SI goes a long way in ensuring that the strategy succeeds. The National Health Strategy (2016-2020) is the product of a long and complex process of intensive consultations, teamwork on specific assignments, detailed studies and information gathering.	The Strategy is relevant to HSDSP AF (V) because it plans for eventualities and is proactive and avoids being reactionary.

No.	RELEVANT OPERATIONAL MANUALS, PROCEDURES AND GUIDELINES	INTERPRETATION	RELEVANCE TO HSDSP AF (V)
		The National Health Strategy 2016-20 derives from the national vision and provides a framework for attaining health and health related goals and objectives. It assumes the spirit of the Zim-Asset that seeks to attain "quick wins" and is structured around the Results Based Management system that focuses on a clear vision, mission, values, key results areas, goals, and objectives. Unlike past strategies, the NHS 2016-20 is complemented by a detailed monitoring and evaluation framework that will be used to assess progress through mid-term and end term evaluations The Constitution further provides, in Section 77 that every person has a right to safe, clean, and potable water, and sufficient food (Food Security, Quality and Safety). These rights are related to peoples' health as it not possible to divorce the living conditions of people from their health risks and status.	
4.	**National Sanitation and Hygiene Strategy**	Zimbabwe's National Action Committee on Water, Sanitation and Hygiene has developed a sanitation and hygiene strategy. The Institute of Water and Sanitation Development (IWSD) says "the strategy puts in place key measures for sustained sanitation and hygiene service delivery in Zimbabwe to eliminate open defecation and other related ills. In the year 2010, the Zimbabwe National Action Committee created its Water Sanitation and Hygiene (WASH) Sector. WASH has helped to combine Zimbabwe's urban and rural sanitization efforts to gain a more organized action plan on how to improve sanitation, restore leadership throughout urban and rural areas, institutionalize Government responsibilities and support sector development.	Ensures that health delivery occurs even in remote areas. Strategy creates a nation that is health conscious
5.	**Approved Health Care Waste Management Plan for Zimbabwe**	The Government of ZIMBABWE has put in place a mechanism to ensure that Health Care Waste (HCW) is taken care of within the institution so as not to endanger the public with contaminated waste. in place in hospitals are incinerators, bottle pits, autoclaves, and other safe waste disposal systems	This plan is relevant to ensure that citizens benefit from Government programs and waste is dealt with according to recommended methods

No.	RELEVANT OPERATIONAL MANUALS, PROCEDURES AND GUIDELINES	INTERPRETATION	RELEVANCE TO HSDSP AF (V)
		A temporary holding place should be in place in all hospitals. Colour coded lined bins should be at every waste collection point and the temporary waste holding place should be fenced, locked, and guarded.	
6.	**Draft Water Quality Monitoring and Water Safety Plan**	Zimbabwe does not have a comprehensive water quality and monitoring and evaluation plan in place, but EMA and ZINWA carry out monitoring and water quality evaluation on all seven catchment areas. A draft has been proposed which integrates all relevant issues. The plan involves several coordinated activities including river surveillances, water monitoring, and land use monitoring and other related activities. EMA and ZINWA used to carry out water quality monitoring and evaluation. Building on this plan can go a long way in coming up with the required document.	It is a major input in the HSDSP AF (V) PROGRAM. Quality water or portable water is important for the health of the population
7.	**National Sanitation and Hygiene Investment Plan**	At the 2014 Sanitation and Water for All High-Level Meeting (SWA HLM), the Government of Zimbabwe made a commitment to develop a sanitation and hygiene policy. Zimbabwe also committed to the act of sustaining participatory health and hygiene education. Zimbabwe has plans to reach all disadvantaged groups such as the poor populations and those living in the most remote or inaccessible areas.	The plan is relevant to the HSDSP AF (V) the plan makes possible to chart a way forward and be proactive.
8.	**Hygiene Promotion Guidelines for Urban Areas (draft)**	Poor hygiene that is now prevalent in urban areas of Zimbabwe should be dealt with through the guidelines. To respond to the emerging challenges, stakeholders have embarked on hygiene promotion programmes in urban areas but there are no clear guidelines in place to guide the Zimbabwean population It should be noted that all HHP approaches should link water supply, sanitation and hygiene promotion to service delivery and health.	Health issues play a major part in HSDSP AF (V) without these urban areas can be a hot bed of disease spreading and epicentre of pandemics and epidemics

4.4 RELEVANT ZIMBABWEAN LEGISLATION

Table 4-3 below discusses the relevant Zimbabwe legislation, their interpretation and relevance to the HSDF V Project. On implementation, HSDSP AF (V) must recognize the requirements of these acts.

Table 4-4 below further discus the subsidiary legislation which supports the legislation in table 4-3. These are the regulations which give teeth to the legislation and on implementation, HSDSP AF (V) must recognize the requirements of these regulations.

Table 4-5 below outlines the licences and permits which are relevant to the implementation, HSDSP AF (V). Participating institutions must apply for the relevant licences so that their operations may remain within the legal requirements of Zimbabwean law.

Table 4-3 Relevant Zimbabwe legislation

No.	LEGISLATION	INTERPRETATION OF LEGISLATION	RELEVANCE TO THE PROJECT
1.	**Environmental Management Act (2002)**	An Act to provide for the sustainable management of natural resources and protection of the environment; the prevention of pollution and environmental degradation; the preparation of a National Environmental Plan and other plans for the management and protection of the environment; the establishment of an Environmental Management Agency and an Environment Fund. The Environmental Management Act attempts to harmonize all pieces of legislation governing the environment. It deals to satisfactory levels with both the brown and green issues. Environmental Impact assessments are also an integral part of the act and are now compulsory. Some of the objectives of this Act are to provide for the sustainable management of natural resources and protection of the environment, and the prevention of pollution and environmental degradation. The Act, in section 3 (2) further states that if any other law is in conflict or inconsistent with it, then the Environmental Management Act shall prevail.	Implementation of the HSDSP AF-(V) This will require that EIA's and ESMP's if any be prepared in accordance with the provisions of the EMA and that EIA regulations were applicable.
2.	**Water Act 20:24, (1998)**	An Act to provide for the development and utilization of water resources of Zimbabwe: • to provide for the establishment, powers and procedures of catchment councils and sub catchment councils. • to provide for the grant of permits for the use of water.	Implementation of the HSDSP AF-(V) availability of water levels the playing field and ensures health for all

No.	LEGISLATION	INTERPRETATION OF LEGISLATION	RELEVANCE TO THE PROJECT
		• to provide for the control of the use of water when water is in short supply. • to provide for the acquisition of servitudes in respect of water. • to provide for the protection of the environment and the prevention and control of water pollution. • to provide for the approval of combined water schemes. • to provide for matters relating to dam works. The Water Act ensures that water bodies are not polluted, and water pollution should be discouraged, and violators should be made to pay heavily through PPP or through custodian sentences. Water is a right to all citizens and its pollution will result in diseases and droughts. One of the objectives of this act is to ensure that women and children who are most vulnerable have an equal chance to access clean potable water all the time.	
3.	**Labour Act (CAP 28:01) (1985)**	This is an act to declare and define the fundamental rights of employees; to define unfair labour practices; to regulate conditions of employment and other related matters; to provide for the control of wages and salaries; to provide for the appointment and functions of workers committees; to provide for the formation, registration and functions of trade unions, employers organizations and employment councils; to regulate the negotiation, scope and enforcement of collective bargaining agreements; to provide for the establishment and functions of the Labour Court; to provide for the prevention of trade disputes, and unfair labour practices; Furthermore, the act is there to regulate and control collective action; to regulate and control employment agencies; and to provide for matters connected with or incidental to the foregoing. The Labour Act hedges against malpractices against workers and against employees. In fact, the act puts in place best work practices. These ensure that all workers are given equal opportunities, safe environment to work in, PPE and insurance. Most portions of the act zero in on the rights of workers, the employer, and the employee.	The project will involve employing project staff, it will also involve working with MoHCC staff and staff of other participating Ministries. The Labour act will be relevant to protect the welfare of all these workers. It will take a pivotal role on how people will be treated, including their employment conditions However, it is worth noting that Health care workers are considered essential services and cannot freely exercise this right to engage in collective job actions. The Law restricts the exercise of this right to maintain essential services. This requirement for Health staff not to conduct job actions applies to all Health Care Workers. Thus, this Act is

No.	LEGISLATION	INTERPRETATION OF LEGISLATION	RELEVANCE TO THE PROJECT
		However, no collective job action may be recommended or engaged in by persons who are engaged in an essential service. Essential services are defined in Section 102(a) of the Labour Act as "any services the interruption of which endangers immediately the life, personal safety or health of the whole or any part of the public" and health care services are part of essential services. The Labour Act further requires employers not to punish the striking workers and prohibits hiring of replacement workers. The Law restricts the exercise of this right to maintain essential services.	important to the project because if the workers were to go on strike, the project will be affected, and delayed since its implementation is essentially through the Health Care workers.
4.	**The Public Health Act (Chapter 15:17)**	The Public Health Act has sections that deal with sanitation and buildings (housing). The Act prohibits creation of nuisance. The act looks at how actions of others may end up affecting the health of the public. Case in point is the air, water and land pollution which consequently leads to lung and other respiratory diseases. This Act has sections which deal with emergency situations, epidemics, etc. such as COVID-19. Sections 35 to 45 deal with emergencies and epidemics: • Special Provisions Regarding Formidable Epidemic Diseases • Powers of Minister where local authority fails adequately to deal with any formidable epidemic disease. • Regulations regarding formidable epidemic diseases. The public health act leaves no stone unturned in the pursuance of guarding the public against being violated and ensure that citizen get health delivering. Some of the sections of the acts focus on how the public has their health safe guarded.	Sanitation and state of health facilities must be such that the patient's health is not compromised. The act will be used to make sure that the public health is at all times looked after.
5.	**Health Service Act (Chapter 15:16) of 2004**	The health service act highlights the need to provide for the establishment of the Health Service Board and its functions; to constitute the Health Service and to provide for its administration and the conditions of service of its members, to provide for the transfer of persons engaged in public health service delivery from the Public Service to the Health Service.	This allows for safe work practices and working conditions during program lifespan. As doctors and nurse work the environment should be conducive and their welfare should be catered for since they are frontline workers.

No.	LEGISLATION	INTERPRETATION OF LEGISLATION	RELEVANCE TO THE PROJECT
6.	**Health Professions Act. Chapter 27:19 of 2000.**	The act seeks to establish a Health Professions Authority of Zimbabwe, • a Medical and Dental Practitioners Council of Zimbabwe, • an Allied Health Practitioners Council of Zimbabwe, • a Natural Therapists Council of Zimbabwe, • a Nurses Council of Zimbabwe, • a Pharmacists Council of Zimbabwe, • a Medical Laboratory and Clinical Scientists Council of Zimbabwe, • an Environmental Health Practitioners Council of Zimbabwe and a Medical Rehabilitation Practitioners Council of Zimbabwe, • and to provide for the composition and functions of the Authority and those councils. • to provide for the registration of persons in health professions and the issue of practicing certificates to registered persons. • to provide for the exercise of disciplinary powers in relation to registered persons. • to provide for disabilities of and offences by unregistered persons who perform acts specially pertaining to health professions in respect of which a register is kept or who represent themselves to be practitioners in any such health profession. • to provide for the registration and control of health institutions and the regulation of services provided therein or there from.	Health issues are relevant to HSDSP AF (V) people in this profession must have governing principles and work ethics which will ensure proper health delivery
7.	**The Medical Services Act. (1999).**	The act stipulates that every citizen and permanent resident of Zimbabwe has the right to have access to basic healthcare services, including reproductive health care services, and Secondly: No person may be refused emergency medical treatment in any health care institution in Zimbabwe. The Bill seeks to provide for the establishment of the Medical Aid Authority, confer functions on such authority in relation to registration and control of certain activities of medical aid societies, to provide for the appointment of the Registrar of Medical Aid Societies, to protect the interests of members of medical aid societies, to amend the Medical Services Act [Chapter 15:13] and the Income Tax Act [Chapter 23:06], and to provide for matters incidental to or connected with the foregoing,	Relevant to HSDSP AF (V) since services from the medical fraternity should be regulated and guided accordingly to ensure safe health all round.

No.	LEGISLATION	INTERPRETATION OF LEGISLATION	RELEVANCE TO THE PROJECT
8.	**Mental Health Act, (1983)**	The Mental Health Act (1983) is the main piece of legislation that covers the assessment, treatment, and rights of people with a mental health disorder. People detained under the Mental Health Act need urgent treatment for a mental health disorder and are at risk of harm to themselves or others. The services of the Mental Health Department will be essential during this stressful Pandemic period. The Department of Mental Health Services coordinates provision of comprehensive mental health and psychiatric services (promotive, preventive, curative and rehabilitative) including substance abuse (Alcohol, Drug and Tobacco Control).	The rights of this vulnerable group always must be safeguarded during the lifespan of the project. If overlooked most may become affected by diseases which could otherwise had been preventable.
9.	**Social Welfare Assistance Act: Chapter 17:06, (1988)**	The Social Service Act provide for the granting of social welfare assistance to persons in need and their dependents; and to provide for matters incidental thereto or connected therewith. The social Welfare assistance applies to any destitute or indigent person, who can apply to the Director in the prescribed form for social welfare assistance in terms of this Act. It must be noted that the Form of social welfare assistance that is granted under this act include financial form in such amount as, having regard to the circumstances of the beneficiary, the Director deems reasonable and sufficient, but shall not exceed such rate as may be prescribed. Various other financial forms may take any of the following forms • rehabilitation, institutional nursing, boarding or foster home care. • counselling services. • the provision of orthopaedic and orthotic appliances. • occupational training. • pauper burials. • the supply of food or clothing.	The population groups which are affected and are vulnerable must fall back on the Social Welfare contingency plans of assisting them.
10.	**Local Government Acts, (2009)**	The Local Government Acts cover several pertinent acts which oil the Local Government machines. The juridical framework for local government is set out in several pieces of legislation.	The Government buy-in heavily depends on the Local Government Acts being religiously adhered to. The local

No.	LEGISLATION	INTERPRETATION OF LEGISLATION	RELEVANCE TO THE PROJECT
		The principal Acts governing local authorities in Zimbabwe, the Urban Councils Act and the Rural District Councils Act set local authorities as separate and autonomous legal corporate institutions. The main Acts for local governance purposes are the Urban Councils Act (Chapter 29:15), Urban Councils Amendment Act (Chapter 29:16), Rural District Councils Act (Chapter 29:13), Chiefs and Headmen Act (Chapter 29:01), Communal Land Act (Chapter 20:04), the Provincial Councils and Administration Act, the Customary Law and Local Courts Act (No. 2) of 1990 and the Traditional Leadership Act of 1998. In addition, there are several statutory instruments defining the legal parameters of local government	government is the heart of the people and the acts will cover the population and ensure their safety and wellbeing
11.	**National Museums and Monuments Act, (2006)**	The National Museum and Monuments Act looks at all issues dealing with archaeological matters. The act protects all areas of historical, architectural, archaeological, and paleontological value. Such sites cannot be altered, excavated, or damaged and material on them cannot be removed without the written consent of the Executive Director of the National Museums and Monuments of Zimbabwe [NMMZ]. The law requires that any monument or relic discovered must be reported in writing to the Executive Director of the NMMZ by the discoverer and the owner of the land on which it is found. Detailed chance find procedures are in Appendix 8 of this ESMF.	The Government should not violate any ethnic group's heritage in the name of trying to contain any epidemic or outbreak in diseases. The HSDSP will curtail any such move. if the implementers are following the guidelines proffered by the consultant.
12.	**Dangerous Drugs Control Act (Chapter 15:02)**	An Act to control the importation, exportation, production, sale, and distribution and use of dangerous drugs Dangerous drugs are governed in accordance with the provisions of the Dangerous Drugs Act [Chapter 15:02]. Authorization to manufacture and sell drugs in terms of this Act is granted by the Minister on such terms and subject to such conditions, including, in the case of a license, the payment of a fee, as the Minister may fix.	Dangerous drug affect health and hence issue is relevant. The compromised position in this area will cause untold health repercussions.

Table 4-4 Relevant Statutory Instruments (SI)

No.	STATUTORY INSTRUMENT	INTERPRETATION OF LEGISLATION	RELEVANCE TO THE PROJECT
1.	**Environmental Management (EIA and Ecosystems Protection) Regulations, 2007**	Of note is the fact that these regulations stipulate regulations for ecosystems protection, conditions for clay and sand extraction and lays out conditions for the submission and review of environmental impact prospectus and reports. Failure to adhere to these regulations may result in a fine or imprisonment for a period not exceeding five years. Once issued, a permit for extraction is valid for a period of one year and is not transferable. The proposed contractor to obtain permits through the EMA for the extraction of clay and sand deposits for construction, and the extraction of gravel for the roads in accordance with requirements of these regulations. Regarding fire, any land user, owner, or designated authority is required to put in place appropriate fire prevention measures on their land/premises. Aptly put, the regulations also prohibit the deliberate lighting of fire that cannot be extinguished and causes damage to the environment, property, or life and the lighting of fire outside residential or commercial premises during 31 July to 31 October each year. Considering the review periods for the Prospectus and ESIA report, the subproject implementation scheduling needs to put the environmental clearances well ahead of the project implementation processes to ensure the environmental clearances will not be the bottleneck to the project implementation	Before, during and after the programme the environment must be protected so that future generations can utilize it. HSDSP AF-(V) PIE will ensure proactive engagement of EMA where such environmental clearances are required for respective subprojects.
2.	**Environmental Management (Effluent and Solid Waste Disposal) Regulations, (SI 6 of 2007)**	This statutory instrument (SI 6 of 2007) under discussion covers sections (60-62, 69-70) of the Environment Management Act (CAP 20:27). It goes on to set minimum requirements for the granting of an effluent and solid waste disposal license as well as the conditions for the validity of the license. Section 23 specifically makes littering a criminal offence punishable by fine or imprisonment. The regulation falls in line with the statute that requires all project vehicles have a waste receptacle that is emptied and a designated waste collection point.	Waste disposal. solid or liquid must be done within hygienic parameters. The project is to function within this paradigm. to achieve maximum efficiency

No.	STATUTORY INSTRUMENT	INTERPRETATION OF LEGISLATION	RELEVANCE TO THE PROJECT
		The project work areas should also be kept litter free through availability of waste receptacles and disposal in authorized points. Contractors shall also ensure that in all project areas that require and do not have toilets, they provide mobile toilets to ensure that there will be no open defecation.	
3.	**SI 76 of 2020** **Civil Protection (Declaration of State of Disaster: Rural and Urban Areas of Zimbabwe)**	This SI under the Civil Protection Act allows the civil protection authorities to use the special powers available to them under the Act to respond to a declared state of disaster. The declaration places the whole country in a state of disaster with effect from the promulgation of this notice.	declares whole country to be in a state of disaster hence relevant. to make people ready for any eventualities.
4.	**SI 77 of 2020** **Public Health (COVID-19) Prevention, Containment and Treatment) Regulations, 2020**	These regulations were made by the Minister of Health and Child Care under the "new" Public Health Act of August 2018. The Act gives the Minister wide powers to legislate measures to prevent, contain and treat the incidence of "formidable epidemic diseases". As a new virus, COVID-19 was not on the existing list of "formidable epidemic diseases" in section 64 of the Public Health Act. It was, therefore, necessary for the Minister of Health and Child Care to make it a "formidable epidemic disease" by a declaration in a statutory instrument under the same section. Section 3 of these regulations contains that declaration called the "FED declaration", which will be in effect until 20th May 2020, unless before that date the Minister extends it. The FED declaration allowed the Minister to invoke the special regulation-making powers conferred on him by section 68 of the Act. The scope of the regulations is indicated by the subjects covered in the headings to sections 5 to 8: • Prohibition of gatherings [of more than 100 persons, whether wholly or partly in the open air or in a building] • Compulsory testing, detention, etc., to contain COVID-19 • Places of quarantine and isolation • Ministerial orders [to be published in the Government Gazette, for controlling traffic and movements of persons, including curfews; closure of places of worship, entertainment, recreation, or amusement; controlling the sale of liquor; prohibiting gatherings of fewer than 100 persons; regulating removal of bodies and conducting of burials; compelling the	This SI is relevant to the HSDSP AF (V) because it looks at ways of prevention, how to contain and treat the disease.

No.	STATUTORY INSTRUMENT	INTERPRETATION OF LEGISLATION	RELEVANCE TO THE PROJECT
		evacuation, closing, alteration or demolition of premises likely to favour the spread of COVID-19]. • There are steep maximum penalties on conviction of breaches of the regulations or orders issued under them: a fine not exceeding level 12 [ZW $36 000] or one year's imprisonment or both. The point of this bulletin is to draw attention to the statutory instruments and to outline what they say. A more in-depth examination of the statutory instruments is planned for a separate bulletin.	
5.	**SI 79 of 2020** **Access to information and protection of Privacy (Registration, Accreditation and Levy) (Amendment) Regulations, 2020-**	The Minister of Information, Publicity and Broadcasting services made it a crime to invade other people's privacy.	Affected people have a right to privacy. If their privacy is invaded, then this will result in untold suffering and harm.
6.	**SI 78 of 2020** **The Management Training Bureau Regulations**	A board should be in place to monitor and regulate the usage of funds and resources during any Government project lifespan. The board is made up people from various departments	HSDSP AF (V) will need this input. Training will ensure that safe methods and use of funds are adopted.
7.	**SI 81 of 2020** **Labour Relations (Specification of Minimum Wages) (Amendment) Notice, 2020**	The minimum wage issue takes the forefront and conditions to exempt paying of the wages must be brought to the ministry for review.	To provide or give incentives to front line workers the issue of wages and allowances must be looked at
8.	**SI 82 of 2020** **Public Health (COVID -19 Prevention Containment and Treatment) (Amendment) Regulation, 2020**	The SI puts in place regulations to reduce the number of people allowed to gather in groups. The SI encourages law enforcing officer to ensure that regulations are adhered to. The issue of prevention, containment and treatment was dealt with. Ministerial orders must be followed and adhered to according to laid down guidelines.	Relevant for HSDSP AF (V) since it deals with prevention, containment and treatment.

No.	STATUTORY INSTRUMENT	INTERPRETATION OF LEGISLATION	RELEVANCE TO THE PROJECT
9.	**SI 83 of 2020** **Public Health (COVID-19 Prevention, Containment and Treatment) (National Lockdown) Order**	The SI looks at the National Lockdown and the prohibition of gatherings and the extension of permits for residence of Foreign Nationals, closure of airports, and aerial transportation. The power to close boarders and enforcement issues are dealt with and the resultant penalty is dealt with. A phased relaxation of the lockdown is also dealt with in this SI.	The SI is relevant to HSDSP AF (V) because the issue of public health is dealt with and prevention, containment and treatment is pertinent.
10.	**SI 84 of 2020** **Public Health (COVID-19 Prevention, Containment and Treatment) (Amendment) regulations, 2020.**	The SI focuses on the amendments on issues highlighted in SI 83. The number of hospital patients is looked at and the issue that queuing people in cars should remain in cars until served. People can go out to get basic foodstuff for ablution facilities and re-fuelling of cars, generators, and other engines.	The SI is relevant since issue of patients is highlighted and movement is allowed carefully
11.	**SI 86 of 2020** **Public Health (COVID-19 Prevention, Containment and Treatment) (National Lockdown) (Amendment) Order**	It deals with the production and distribution of medical supplies, the issue of funerals, funeral parlours and making, manufacturing and sale of coffins. The conduct of agricultural activities on farms and harvest of crops is closely monitored. Agricultural inputs and stock feed were also an issue and distribution of medical equipment for domesticated farm animals was regulated.	This is relevant because it deals with funeral gatherings and how to proceed.
12.	**S.I 103 of 2020** **Public health (COVID 19 prevention, containment, and treatment) (amendment) regulations, 2020**	The SI makes screening and testing mandatory and must remain in force even after expiry of the national lockdown. For all workers who were on lockdown and are coming to work should screened and tested for the virus. The use of Rapid Diagnostic Tests (RDT) in Zimbabwe according to the World Health Organisation guidelines is in place. Persons who are essential services should be tested regularly. Sanitizers and hand washers should be put on all office entrances. A law enforcement officer can randomly visit any workplaces without notice. The officer can close any premise as they see fit, by writing or other formal means. Persons who fail to comply will be fined	Relevant since screening is made mandatory to save the lives of others.

No.	STATUTORY INSTRUMENT	INTERPRETATION OF LEGISLATION	RELEVANCE TO THE PROJECT
13.	**SI 102 of 2020 Public health (COVID 19) SI 102 of 2020.**	The SI empowers law enforcement officers to gain access to any land or premises where exempted persons are present or employed and demand documentary proof of RDT or other tests.	Relevant since this allows officer to enforce compliancy

Table 4-5 Relevant Licences and Permits

No.	STATUTORY INSTRUMENT	INTERPRETATION OF LEGISLATION	RELEVANCE TO THE PROJECT
1.	**Environmental Management (Control of Hazardous Substances) (General) Regulations, 2018.**	**Hazardous Waste Transportation Licence** The Hazardous Waste Transportation licences are issued by EMA, as per the Environmental Management (Control of Hazardous Substances) (General) Regulations, 2018. The licences are issued according to the same classification system as the incinerator emission licences. No operator can transport any type of a hazardous substance consignment whether by air, road, water, pipeline, or rail without a licence issued to the operator by the Agency. The permits can be obtained from the Environmental Management Authority upon submission of facility details, quantity and quality of waste being handled, It takes an average of two weeks to obtain the permit. The average fee is $322.89 per annum.	Most of the project health care facilities do not have incinerators and depend on nearby institutions which have an incinerator. To transport the waste the institutions will need to apply for a hazardous waste transportation license. If they are using a private transporter, the transporter will need to apply for the permit.
2.	**Environmental Management (Control of Hazardous Substances) (General) Regulations, 2018**	**Waste Enterprise Licence** A Waste Enterprise licence is a licence issued to a business that handles waste, i.e., collects, stores, treats and disposes the final residue properly. Waste Enterprise licence is issued in terms of the Environmental Management (Control of Hazardous Substances) (General) Regulations, 2018. The licences are issued according to the same classification system as the incinerator emission licences.	Businesses that handle waste, i.e., store, treat and dispose final residue need to have this license so Health Care Facilities and transporters need this license. This SI will be applicable to the project as

No.	STATUTORY INSTRUMENT	INTERPRETATION OF LEGISLATION	RELEVANCE TO THE PROJECT
		The permits can be obtained from the Environmental Management Authority upon submission of facility details, quantity and quality of waste being handled, It takes an average of two weeks to obtain the permit. The average fee is $ 134.65 per year.	waste generated from the participating facilities will need to be treated and disposed of properly.
3.	**Statutory Instrument 206, Water (Permits) Regulations of 2001.**	Through this SI, the Zimbabwe National Water Authority (ZINWA) administers a water permit system. A water permit is the authority one obtains to have certain rights to water use in terms of the Water Act. • Anyone intending to drill a borehole must first seek authorization to drill the borehole from the appropriate Catchment Council. It is illegal to drill a borehole without the authorization. • Anyone, intending to abstract or store surface or ground water for any purpose including for primary purpose, must register or apply for a permit.	This SI will be utilised by the project for any institution that will be supported to install a water tank and will be abstracting water from either a surface source or borehole.
4.	**Food and Food Standards (Inspection and Certification) Regulations, 2015**	Among other things the SI provides for the management and monitoring of water quality for potable purposes, Section 9. (1) outlines that the Secretary shall monitor the quality and safety of water and ascertain the status of drinking water in any area and, for that purpose, direct local authority, environmental or other health officers or inspectors to collect and submit to the Government Analyst Laboratory for analysis, according to a specified regular schedule, water samples from communal boreholes and distribution systems.	This SI will be utilised by the participating institutions which will be assisted with Water Tanks. The PIE will have to ascertain that the water quality of the source (Borehole) was analysed and if not cause it to be analysed. Also, the water quality will have to be periodically checked.
5.	**Zimbabwe Food and Food Standards (FFS) (Mineral and Bottled Water) Regulations 2002**	This SI, the Food and Food Standards (FFS), provides for the standardisation of Natural, Mineral Water and Bottled Water for potable purposes. The FFS are equivalent to the WHO Guidelines for Drinking Water Quality and are used in determining the suitability of a water source for drinking purposes.	This SI will be utilised by the participating institutions which will be assisted with Water Tanks. The PIE will have to ascertain that the water quality of the source (Borehole) meets the laid down standards in this SI.
6.	**Section 34 of the Water Act (CAP 20:24) and SI 206/2001**	**Borehole Drilling Authorities**	All participating Institutions which will get assistance in the drinking

No.	STATUTORY INSTRUMENT	INTERPRETATION OF LEGISLATION	RELEVANCE TO THE PROJECT
		in terms of section 34 of the Water Act (CAP 20:24) and SI 206/2001, before a borehole is drilled, authorization to drill the borehole must be sought first from the appropriate Catchment Council. It is illegal to drill a borehole without the authorization and all boreholes must be registered with the Zimbabwe National Water Authority (ZINWA) or the nearest Catchment Council Offices.	water supplies, must abide by this requirement and apply for authorisation before drilling a borehole and get the borehole registered with ZINWA or the relevant Catchment Council.
7.	**in terms of section 34 (1) and (2) of the Water Act (CAP 20:24) and SI 206/2001**	**Groundwater Abstraction Permits** in terms of section 34 (1) and (2) of the Water Act (CAP 20:24) and SI 206/2001, an abstraction permit is required before abstracting groundwater. It is illegal to abstract water without a valid permit obtainable from the appropriate Catchment Council.	All participating Institutions which will get assistance in the drinking water supplies, must abide by this requirement if their source is a borehole. They must apply for a groundwater Abstraction Permit from ZINWA or the relevant Catchment Council.
8	in line with: ● Section 9 (1) of the Food and Food Standards (Inspection and Certification) Regulations, 2015, ● the Zimbabwe Food and Food Standards (Mineral and Bottled Water) Regulations 2002	**Water Quality Analysis** Once the borehole has been drilled for potable water purposes, the quality of the water has to be ascertained in line with Section 9 (1) of the Food and Food Standards (FFS) (Inspection and Certification) Regulations, 2015, together with requirements of the Zimbabwe Food and Food Standards (FFS) (Mineral and Bottled Water) Regulations 2002 (Which are equivalent to the WHO Guidelines for Drinking Water Quality). Poor quality water poses a serious risk to humans, crops, livestock and the environment. This is in line with the General EHS 2007 "Water Quality" states "water quality should comply with national acceptability standards or in their absence the current edition of with WHO Drinking Water Guidelines." Water quality for more sensitive well-being-related demands such as water used in health care facilities or food production require stringent, industry-specific guidelines or standards, as provided for by the FFS.	The drinking Water quality of All participating Institutions which will get assistance in the drinking water supplies, must tested regularly; quarterly for groundwater and monthly for surface water sources.

4.5 INTERNATIONAL CONVENTIONS AND TREATIES

Zimbabwe is a signatory and party to more than twenty-one international, conventions, treaties, and protocols. Of the many treaties, the following listed below are relevant to the HSDSP AF-(V).

Table 4-6 Overview of the relevant International Conventions and Treaties

No.	INTERNATIONAL CONVENTIONS	INTERPRETATION	RELAVANCE TO HSDSP AF (V)
1	**International Health Regulations Minamata Declaration**	The Minamata Convention is a legally binding agreement that aims to protect human health and the environment from the adverse effects of mercury. It includes a ban on primary mercury mining; the phase-out of existing mines and the phase-out and phase-down of mercury use in several products and processes; control of mercury releases into the environment and management of contaminated sites The purpose and scope of the International Health Regulations (2005) are "to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade"	Health of the population should be safeguarded.
2	**Libreville declaration**	The main outcome of that historic meeting was the adoption of the Libreville Declaration, which recognized that human health is intimately related to the state of the environment. The participating nations committed themselves to 11 priority actions for addressing the continent's most pressing health and environment challenges. • It must be noted that the Libreville Declaration was a springboard for tackling the environmental risks to human health and ecosystem integrity across the African continent, including the great considerable health impacts of climate change. • WHO played a pivotal role in the declaration?	The declaration is relevant to HSDSP AF (V)
3	**Stockholm Convention**	The Stockholm Convention on Persistent Organic Pollutants is a multilateral international environmental agreement to protect human health and the environment from chemicals, known as POPs. These so-called POPs have harmful impacts on human health or on the environment at large.	Issues touch on human health which the HSDSP AF (V) seeks to address, thus, the provisions of this convention must be adhered to in

No.	INTERNATIONAL CONVENTIONS	INTERPRETATION	RELAVANCE TO HSDSP AF (V)
		The Stockholm Convention on Persistent Organic Pollutants is a global treaty to protect human health and the environment from chemicals that remain intact in the environment for long periods, become widely distributed geographically, accumulate in the fatty tissue of humans and wildlife, and have harmful impacts on human health or on the environment	handling any health care waste in the HSDSP AF-(V) project.
4	**Luanda Commitment**	This was a commitment to ensure that the Libreville Declaration does not gather durst but that it should be implemented, the health-related issues are tackled, there is poverty reduction i and water is supplied to vulnerable groups. Angola and Sierra Leon agreed to implement these health issues that affect both countries. On the commitment several subjects were agreed on and the two countries undertook to work together on these issues. These Goals were in the form of the 2030 Agenda and were to ensure that citizens benefit in terms of health services.	Relevant since it is on health issues.
5	**The Basel Convention**	The ***Basel Convention Technical Guidelines*** focus on reducing the impacts on health and the environment of biomedical and healthcare wastes that is based on the major classification in Annexes I, II, VII of the Basel Convention, but specified for practical use in the healthcare sector. This guideline focuses on, (i) a strict definition and classification of the relevant waste streams, (ii) the segregation at source of the waste and (iii) the access to the best available information for the identification of waste.	The activities of the HSDSP AF-(V) project may induce an increase in the use of medical facilities and hence an increase in the generation of Health care Waste. The project will manage these anticipated increases through the ICWMP.

4.6 WORLD BANK SAFEGUARDS POLICIES OVERVIEW

The World Bank has ten (10) environmental and social safeguard policies that it uses to determine potential environmental risks and benefits associated with Bank funded projects. The environmental and social safeguard policies are designed to avoid, mitigate, or minimise adverse environmental and social impacts of projects supported by the Bank. Table 1-1 in Chapter one also discusses the Safeguard Policies which were triggered by this project in-depth.

4.6.1 Bank Policies Triggered

The World Bank Safeguard Policies that it uses to examine potential environmental and social risks and benefits associated with Bank funded projects are designed to avoid, mitigate, or minimise adverse environmental and social impacts of projects supported by the Bank. Table 1-1 below is a summary of the Safeguard Policies that will be triggered by the HSDSP AF-(V):

Table 4-7 Bank Policies Triggered

No.	SAFEGUARD POLICIES	TRIGGERED?	EXPLANATION (OPTIONAL)
1.	Environmental Assessment OP/BP 4.01	Yes	The proposed AF will continue to support mostly activities that are aligned with the parent project and current AF. There will be some modifications based on lessons learnt during implementation and new activities on COVID-19 emergency preparedness and response. The project will cover more and new areas (with some possibly nationwide interventions) and include some new activities such as water and sanitation installation. The project will have positive impacts as it will improve COVID-19 surveillance, monitoring and containment. OP 4.01 is triggered due to the potential environmental impacts related to the minor civil works activities such as minor sanitation structures (such as septic tanks or pit latrines, ventilated improved pit latrines, composting toilets, or pit latrines with slabs), and the installation of water tanks in selected isolation centres, supplies for handwashing facilities and basic sanitation facilities in critical areas will be supported. These minor activities will be site-specific and will not have any significant environmental impacts on the ground. The ESMF and ICWMP will guide on the best practices for waste management and any other safeguards concern that may be identified including any necessary labour management measures. The ICWMP will present mitigation measures that consider the limited capacity level of the health sector. Site-specific ESMPs or checklists will be prepared as needed during implementation.
2.	Performance Standards for Private Sector Activities OP/BP 4.03	No	The AF will not finance any private sector activities
3.	Natural Habitats[5] OP/BP 4.04	No	The policy is not triggered as the AF will be restricted to already existing health facilities. No health facilities are located in any

[5] **Natural habitats** are land and water areas where (i) the ecosystems' bio-logical communities are formed largely by native plant and animal species, and (ii) human activity has not essentially modified the area's primary ecological functions. (See OP 4.04, Annex 1 for full definition).
Critical natural habitats are (i) existing protected areas and (ii) areas officially proposed by governments as protected areas, (iii) areas initially recognized as protected by traditional local communities (e.g., sacred groves) (of known high

No.	SAFEGUARD POLICIES	TRIGGERED?	EXPLANATION (OPTIONAL)
			protected areas. Any project related activities that may impact natural habitats will be identified in screening and appropriate measures taken as directed in the ESMF.
4.	Forests OP/BP 4.36	No	The AF will not involve any forests and no facilities are located in a forest; any activities with potential to impact forests will be identified in screening and appropriate measures taken as directed in the ESMF.
5.	Pest Management OP 4.09	No	The policy is not triggered as the AF will not finance the purchase of or use of pesticides.
6.	Physical Cultural Resources OP/BP 4.11	No	The project activities will only finance minor improvements for already existing structures which do not have PCR. This ESMF include chance-find procedures as a precautionary measure in Appendix 8.
7.	Indigenous Peoples OP/BP 4.10	Yes	There is a possibility that indigenous communities could be present in or near several areas targeted by Component 4 (COVID response). If their presence is confirmed, the project will address any risks posed to them and measures put in place to ensure that they receive culturally appropriate benefits. This will be done through the specific targeting of stakeholder engagement activities relevant to Indigenous Peoples (IPs) that meet the requirements of OP4.10 and that a Social Assessment (SA) is carried out prior to any activities that would impact them. Following the SA, and as appropriate: (i) a stand-alone plan or framework may be developed; (ii) or key elements of risk mitigation and culturally appropriate benefits will be included in the ESMF. In case where indigenous communities will be affected by quarantine provisions or other targeted impacts, site-specific approaches will ensure adequate consideration of their specific cultural needs in accordance with OP 4.10, to the satisfaction of the Bank. Public consultations with representatives of indigenous communities and their organizations are provided for in the ESMF and will be further developed in subsequent IPPFs as appropriate considering their circumstances. IP organizations and representatives will be consulted during the preparation of the ESMF and IPPFs as necessary.
8.	Involuntary Resettlement OP/BP 4.12	No	No project activities require land acquisition or adversely impact livelihoods. Financing may support rehabilitation and minor upgrades at existing facilities.
9.	Safety of Dams OP/BP 4.37	No	The AF will not involve the construction of dams.
10.	Projects on International Waterways OP/BP 7.50	No	The AF will not involve international waterways.
11.	Projects in Disputed Areas OP/BP 7.60	No	The AF will not involve disputed areas.

4.6.2 World Bank Group Environmental Health and Safety Guidelines (EHS)

In addition to the Safeguards Policies, the project will follow the World Bank Group Environment, Health and Safety Guidelines. For details, refer to: www.ifc.org/EHSguidelines, (IFC, 2007).

conservation value) and (iv) sites that maintain conditions vital for the viability of these protected areas (See OP 4.04, Annex A Para.I.[b] for full definition.)

World Bank Group Environment, Health and Safety (EHS) guidelines[6] are technical reference documents with general and industry-specific examples of Good International Industry Practice (GIIP). They define acceptable pollution prevention and abatement measures and emission levels in World Bank financed projects.

The EHS Guidelines contain the performance levels and measures that are generally considered to be achievable in new facilities by existing technology at reasonable costs. Application of the EHS Guidelines to existing facilities may involve the establishment of site-specific targets, with an appropriate timetable for achieving them. The application of the Guidelines to existing facilities may involve the establishment of site-specific targets with an appropriate timetable for achieving them.

The environmental assessment process may recommend alternative (higher or lower) levels or measures, which, if acceptable to the World Bank, become project- or site-specific requirements.

If less stringent levels or measures than those provided in the EHS Guidelines are appropriate, in view of specific project circumstances, a full and detailed justification for any proposed alternatives is needed as part of the site-specific environmental assessment. This justification should demonstrate that the choice for any alternate performance levels is protective of human health and the environment. When host country regulations differ from the levels and measures presented in the EHS Guidelines, projects are expected to achieve whichever is more stringent.

Box 2.

General EHS Guidelines

1. Environmental
1.1 Air Emissions and Ambient Air Quality
1.2 Energy Conservation
1.3 Wastewater and Ambient Water Quality
1.4 Water Conservation
1.5 Hazardous Materials Management
1.6 Waste Management
1.7 Noise
1.8 Contaminated Land

2. Occupational Health and Safety
2.1 General Facility Design and Operation
2.2 Communication and Training
2.3 Physical Hazards
2.4 Chemical Hazards
2.5 Biological Hazards
2.6 Radiological Hazards
2.7 Personal Protective Equipment (PPE)
2.8 Special Hazard Environments
2.9 Monitoring

3. Community Health and Safety
3.1 Water Quality and Availability
3.2 Structural Safety of Project Infrastructure
3.3 Life and Fire Safety (L&FS)
3.4 Traffic Safety
3.5 Transport of Hazardous Materials
3.6 Disease Prevention
3.7 Emergency Preparedness and Response

4. Construction and Decommissioning
4.1 Environment
4.2 Occupational Health and Safety
4.3 Community Health and Safety

The Project will apply the General Guidelines, including (i) Environmental, (ii) Occupational Health and Safety, (iii) Community Health and Safety and (iv) Construction and Decommissioning. Other relevant EHS may include Health Care Facilities (2007) and Water and Sanitation (2007).

[6] A complete list of industry-sector guidelines can be found at: www.ifc.org/ifcext/enviro.nsf/Content/EnvironmentalGuidelines

4.7 GAP ANALYSIS

4.7.1 Zimbabwean Legislation and applicable World Bank Safeguards

This section presents the gaps analysis between the Zimbabwean Legislation and applicable World Bank Safeguards. This gap analysis specifies aspects where there are gaps between national and international standards, analyses the gap and states actions to be undertaken by the HSDSP regarding these aspects.

Table 4-8 Gap Analysis - Zimbabwean Legislation and applicable WB Safeguards

No.	WORLD BANK POLICY	ZIMBABWE LEGISLATION	GAP ANALYSIS	RECOMMENDED ACTION IN HSDSP
1.	**Environmental Assessment (OP/BP 4.01)**			
1.1	**EA Process**			
	Environmental Assessment (OP/BP 4.01) outlines Bank policy and procedure for the environmental assessment of Bank lending operations. The Bank undertakes environmental screening of each proposed project to determine the appropriate extent and type of EA process. Environmental Assessment (EA) work is initiated as early as possible in project processing and is integrated closely with the economic, financial, institutional, social, & technical analyses of all proposed projects.	**The Environment Management Act (CAP 20:27) of 2012** defines the environmental management principles for the country, including the consideration of people and their needs. It sets out environmental standards that should be complied with, including waste management and hazardous substances management. **The Environmental Impact Assessment Policy (1997)** guides the implementation of environmental impact assessments and was designed to attract environmentally responsible investment and development in Zimbabwe; maintaining the long-term ability of natural resources to support human, plant and animal life; avoid irreversible environmental damage and minimize such environmental damage where it cannot be avoided; conserving broad diversity of plants, animals and ecosystems and the natural processes that they rely on; conserving the social, historical and cultural values of people and their communities; meeting the basic needs of people affected or likely to be affected by development proposals, including food, water, shelter; health and sanitation.	There are no significant gaps between the OPs and national laws. The EMA Act starts at the ESIA process while the World bank OPs provide for an ESMF. The two converge at the screening point though the screening process is different EMA uses a prescriptive list while the WB uses a screening guideline. So, it is possible for some projects that may not be in the EMA prescribed list, to require ESIA from the WB screening process or vice versa. Therefore, the screening process need to be merged as follows: • If subproject is prescribed by EMA while WB does not, ESIA will be done. • If WB screening requires ESIA while EMA did not prescribe the project for ESIA, ESIA is conducted.	Screening of key environmental and social risks and impacts of the sub-projects must always be undertaken and appropriate mitigation measures identified, as laid out in this ESMF. Stakeholder engagement must be a continuous process to keep checking if the project is still on track. If a sub-project has adverse impacts, a site specific ESMP must be developed and submitted to EMA for synchronisation with the parent ESMF This Project will apply waste the ICWMP requirements as a major mitigation measure. Depending on the screening outcomes, some sub-projects may require site specific ESMPs.

No.	WORLD BANK POLICY	ZIMBABWE LEGISLATION	GAP ANALYSIS	RECOMMENDED ACTION IN HSDSP
		The first schedule of the Act stipulates the activities that are prescribed for full environmental impact assessments (EIA). This includes the drainage and irrigation, forestry and water supply.		
1.2	**Project Screening and Categorization**			
	The World Bank requires that all projects financed by the Bank are screened for their potential environmental and social impacts to determine the appropriate extent and type of environmental work. The Bank classifies the proposed projects into one of four categories as follows: **Category A:** significant adverse impacts that are sensitive, diverse, or unprecedented. **Category B:** less adverse, site – specific, reversible; can be mitigated **Category C:** minimal or no adverse environmental impacts. **Category FI**: If it involves a financial intermediary	**The Zimbabwe legislation** classifies projects and activities into three types as follows: **Type 1: listed in the Schedule,** have significant adverse impacts, projects require a full EIA. **Type 2**: **listed in the Schedule,** less significant impacts, easy to predict. Mitigatable, do not require a full EIA. **Type 3**: **not listed in the Schedule,** unlikely to cause any significant impacts, do not require any additional environmental assessment.	The Bank requires that all projects be screened, and the requisite environmental assessment work be carried out based on these screening results. To ensure that future small-scale sub-projects are implemented in an environmentally and socially sustainable manner the bank has developed an environmental and social screening process for small scale sub-projects consistent with OP 4.01. The Zimbabwe EA screening procedures uses a prescriptive list while the WB uses a screening guideline. So, it is possible for some projects that may not be in the EMA prescribed list, to require ESIA from the WB screening process or vice versa.	Therefore, the HSDSP AF-(V) will use the environmental and social screening process as described in this report
1.3	**Environmental and Social Management Framework (ESMFs)**			
	The World Bank uses the ESMF used for screening of sub-projects where the sites and potential adverse localized impacts cannot be identified prior to the appraisal of the project.	**The Zimbabwe legislation** has no provision for screening of sub-projects where the sites and potential adverse localized impacts cannot be identified prior to the appraisal of the project.	No provision for screening of sub-projects where the sites and potential adverse localized impacts cannot be identified prior to the appraisal of the project	Therefore, the HSDSP AF-(V) will use the current ESMF as a tool for environmental and social screening where the sites and potential adverse localized impacts cannot be identified prior to the appraisal of the project.
1.4	**Environmental and Social Management Plans (ESMPs)**			
	The World Bank requires ESMPs for each set of activities (e.g., sub-projects) that may require specific mitigation, monitoring and institutional measures to be taken	In addition to EIS for category 3 projects, in the EMA Act, no other plans are prepared.	No provision for further EA work in Zimbabwean Legislation.	ESMPs will be prepared for sub-project as and when required and will include specific mitigation, monitoring and institutional measures to be taken during implementation

No.	WORLD BANK POLICY	ZIMBABWE LEGISLATION	GAP ANALYSIS	RECOMMENDED ACTION IN HSDSP
	during implementation			
1.5	**Pollution Prevention and Management**			
	The World Bank requires through the implementation of the ESMPs the prevention of all forms of pollution and the management of any waste generated.	**Environment Management Act (CAP 20:27) OF 2002** The Act sets out environmental standards that should be complied with, including waste and hazardous substances management. It Utilizes the following statutory instruments: **i) Statutory Instrument 6 o f 2007 (water pollution control and waste management.)** The instrument defines the EMA water pollution control and waste management objectives. **ii) Statutory Instrument 12 of 2007 (Hazardous Substances, Pesticides and Toxic Substances Regulations)** This statutory instrument defines the provisions and standards of handling Hazardous Substances, Pesticides and Toxic Substances. It also stipulates the procedures to be followed when there is an accidental spillage of the substance. In addition, any person whose substances affect the environment are liable to pay for the cost of restoring the environment. **iii) The Zimbabwe National Sanitation and Hygiene Policy (2017).** The Policy sets out safe or hygienic separation of human excreta and other waste from human contact. It covers processes and behaviours for establishing and managing domestic and workplace and public facilities necessary for waste or excreta containment, collection, treatment, and disposal	The Zimbabwean legislation is in line with the provisions of Environmental Assessment (OP/BP 4.01). Thus, there are no significant gaps between OP/BP 4.01 and the national laws.	It is anticipated that the HSDSP AF-(V) activities will generate medical and construction waste. The Project will thus ensure appropriate waste management in all the activities and be fully compliant with WB requirements and the National Laws. Contractors will be required to prepare waste management plans.

No.	WORLD BANK POLICY	ZIMBABWE LEGISLATION	GAP ANALYSIS	RECOMMENDED ACTION IN HSDSP
		The Public Health Act (Chapter 15:17) The **Public Health Act** has sections that deal with sanitation and buildings (housing). The Act prohibits creation of nuisance. The act looks at how actions of others may end up affecting the health of the public. Case in point is the air, water and land pollution which consequently leads to lung and other respiratory diseases. Dangerous Drugs Control Act (Chapter 15:02) This Act controls the importation exportation, production, sale, and distribution and use of dangerous drugs, thus protecting people from direct ill health and poisoning from the dangerous drugs and ultimately pollution of the environment from the disposal of these drugs.		
1.6	**Managing Emergency Situations**			
	The World Bank requires through the institution and implementation of the **Contingency Emergency Response Component** (**CERC)** The CERC is there for contingency measures against a variety of natural disasters, floods, droughts, pest and diseases, frost, hailstorms, and Thunderstorms. These phenomena cause damages to properties, infrastructure, and livelihoods; they impede and set back development efforts, divert development funds and above all loss of lives. The Contingent Emergency Response Component **(**CERC) enables the project to provide a swift response in the event of an	**SI 76 of 2020** **Civil Protection (Declaration of State of Disaster: Rural and Urban Areas of Zimbabwe)** This SI under the Civil Protection Act allows the civil protection authorities to use the special powers available to them under the Act to respond to a declared state of disaster. The declaration places the whole country in a state of disaster with effect from the promulgation of this notice. **SI 77 of 2020 to SI 103 of 2020** **Public Health (COVID-19) Prevention, Containment and Treatment) Regulations, 2020** These regulations were made by the Minister of Health and Child Care under the "new" Public Health Act of August 2018. The Act gives the Minister wide powers to legislate measures to prevent, contain and	Both the Zimbabwean Legislation and the WB directives make provisions for emergency situations. So, there is no Gap between the two	The country is already under a state of emergency and Component 4 of the project will take care of the emergency response to COVID 19 Pandemic so that the project implementation does not get adversely affected by the pandemic.

No.	WORLD BANK POLICY	ZIMBABWE LEGISLATION	GAP ANALYSIS	RECOMMENDED ACTION IN HSDSP
	Eligible Crisis or Emergency[7]. This is done by redirecting a portion of the undisbursed project resources, from other components of the project to address immediate post-crisis and emergency financing needs (World Bank, 2017).	treat the incidence of "formidable epidemic diseases". As a new virus, COVID-19 was not on the existing list of "formidable epidemic diseases" in section 64 of the Public Health Act. It was, therefore, necessary for the Minister of Health and Child Care to make it a "formidable epidemic disease" by a declaration in a statutory instrument under the same section. Section 3 of these regulations contains that declaration called the "FED declaration", and by way of this SI the Pandemic is handled.		
1.7	**Disclosure**			
	World Bank requires ESA reports to be: a) disclosed for written comments from the various agencies and government agencies b) notify the public of the place and time for its review and c) solicit oral or written comments from those affected	**Zimbabwe's Access to Information and Protection of Privacy Act (2002).** The Act sets out that members of the public have a right to access information held by public bodies.	While the Act spells out right to information held by public bodies, the Bank recognizes the importance of open and transparent engagement vis- à-vis project stakeholders by the borrower	Upon completion of ESA reports, these must be: • circulated for written comments from the various agencies and government agencies. • notify the public of the place and time for its review; and • solicit oral or written comments from those affected.
2.	**NATURAL HABITATS (OP/BP 4.04)**			
	The conservation of natural habitats[8], is	The Zimbabwean Legislation employs the following	The Zimbabwean legislation is in line with the	The Project will comply with both the Natural

[7] This is an event that has caused, or is likely to imminently cause, a major adverse economic and/or social impact associated with natural or man-made crises or disasters, (OP/BP 8.00, *Rapid Response to Crises and Emergencies.)*

[8] **Natural habitats** are land and water areas where (i) the ecosystems' bio-logical communities are formed largely by native plant and animal species, and (ii) human activity has not essentially modified the area's primary ecological functions. (see OP 4.04, Annex 1 for full definition).
Critical natural habitats are (i) existing protected areas and (ii) areas officially proposed by governments as protected areas, (iii) areas initially recognized as protected by traditional local communities (e.g., sacred groves) (of known high conservation value) and (iv) sites that maintain conditions vital for the viability of these protected areas (See OP 4.04, Annex A Para.I.[b] for full definition.)

No.	WORLD BANK POLICY	ZIMBABWE LEGISLATION	GAP ANALYSIS	RECOMMENDED ACTION IN HSDSP
	essential for long-term sustainable development. The Bank does not support projects involving the significant conversion of natural habitats unless there are no feasible alternatives for the project and its siting, and comprehensive analysis demonstrates that overall benefits from the project substantially outweigh the environmental costs. If the environmental assessment indicates that a project would significantly convert or degrade natural habitats, the project should include mitigation measures acceptable to the Bank.	Statutory instruments to protect natural habitats: i) **Statutory Instrument 6 of 2007 (water pollution control and waste management**.) The instrument defines the EMA water pollution control and waste management objectives **ii) Statutory Instrument 7 of 2007 (protection of eco systems)** This Statutory Instrument compels all EIA consultants to be corporate, multi-skilled and registered with EMA and deliver a certain quality of work, defined in the regulation. **The Public Health Act (Chapter 15:17)** The Act prohibits creation of nuisance. The act looks at how actions of others may end up affecting the health of the public. Case in point is the air, water and land pollution which consequently leads to the degradation of habitats.	provisions of Environmental Assessment (OP/BP 4.01). Thus, there are no significant gaps between OP/BP 4.01 and the national laws.	Habitats (OP/BP 4.04). and the Zimbabwean Statutory Instruments since there is no gap in the two.
3.	**INVOLUNTARY RESETTLEMENT (OP/BP 4.12)**			
	The Involuntary Resettlement (OP/BP 4.12) policy covers direct economic and social impacts that both result from Bank-assisted investment projects, and are caused by (a) the involuntary taking of land resulting in (i) relocation or loss of shelter; (ii) loss of assets or access to assets, or (iii) loss of income sources or means of livelihood, whether or not the affected persons must move to another location; or (b) the involuntary restriction of access to	The Zimbabwe Legislation that caters for involuntary displacements is the "Land Acquisition (Disposal of Rural Land) Regulations 1999" Subject to these regulations, the owner of any rural land, other than the State, a local authority, or a statutory body, shall not sell the land unless he has offered to sell it to the Minister and i) If the owner of any rural land which was the subject of an offer in terms of section 3 rejects a price proposed by the Minister in terms of	There are significant gaps in due process issues related to land acquisition in Zimbabwe. People can easily be resettled to make way for projects without due compensation.	The project did not trigger this policy. However, in case anything crops up, the provisions of the Involuntary Resettlement (OP/BP 4.12). The Zimbabwean legislation does not affect the implementation of the project since there is no potential for resettlement Any activities that require resettlement of people will be screened out., and all livelihoods

No.	WORLD BANK POLICY	ZIMBABWE LEGISLATION	GAP ANALYSIS	RECOMMENDED ACTION IN HSDSP
	legally designated parks and protected areas resulting in adverse impacts on the livelihoods of the displaced persons..	subsection (4) of section 5, the Minister shall, within ninety days after being notified of the rejection, commence negotiations with the owner regarding the price to be paid by the President for the rural land concerned. ii) If negotiations referred to in subsection (1) conclude without an agreement being reached on the price to be paid for the rural land concerned, the Minister shall, within forty-five days after the conclusion of the negotiations, issue the owner of the land with a certificate of no present interest; or notify the owner, in writing, that it is intended to acquire the land compulsorily in terms of this Act; or to resume ownership of the land in terms of any condition in the land's title deed. iii) Negotiations shall be deemed to have concluded without agreement for the purposes of subsection (2) if no agreement is reached on the price payable for the rural land concerned within fourteen days from the commencement of the negotiations.		will be protected in accordance with the Involuntary Resettlement (OP/BP 4.12).
4	**INDIGENOUS PEOPLES (OP/BP 4.10)**			
	The **Indigenous Peoples (OP/BP 4.10)** directive provides guidance to ensure that indigenous peoples benefit from development projects, and to avoid or mitigate adverse effects of Bank-financed development projects on indigenous peoples. Measures to address issues pertaining to indigenous peoples must be based on the informed participation of the indigenous people themselves. Sub-	The Government of Zimbabwe does not identify any specific group as indigenous, arguing that all Zimbabweans are indigenous peoples. However, there are two peoples who self-identify as indigenous in Zimbabwe; these are the: i) Tshwa (Tyua, Cuaa) San, who are found in the Tsholotsho District of Matabeleland North Province and the Bulalima-Mangwe	There are significant gaps in the Zimbabwean Legislation (which argues that there are no indigenous peoples) and the provisions of the World Bank's Indigenous Peoples (OP/BP 4.20) Policy which gives guidance on how to involve the IPs.	Because the Zimbabwean Legislation does not provide for IPs, the project will apply the provisions of the World Bank's Indigenous Peoples (OP/BP 4.10) Policy, whenever it encounters the IPs.

No.	WORLD BANK POLICY	ZIMBABWE LEGISLATION	GAP ANALYSIS	RECOMMENDED ACTION IN HSDSP
	projects that would have negative impacts on indigenous people will not be funded under the proposed project.	District of Matabeleland South Province in western Zimbabwe ii) Doma (Wadoma, Vadema) of Chapoto Ward in Guruve District and Mbire District of Mashonaland Central Province and Karoi District of Mashonaland West Province in the Zambezi Valley of northern Zimbabwe.		
5.	**Physical Cultural Resources (OP/BP 4.11)**			
	Physical Cultural Resources (OP/BP 4.11) The Bank's general policy regarding cultural property is to assist in their preservation, and to seek to avoid their elimination. Specifically, the Bank (i) normally declines to finance projects that will significantly damage non-replicable cultural property and will assist only those projects that are sited or designed so as to prevent such damage; and (ii) will assist in the protection and enhancement of cultural properties encountered in Bank-financed projects, rather than leaving that protection to chance.	Zimbabwe uses **National Museums and Monuments Act (CAP 25:11)** to protect Cultural Property The Act protects all areas of archaeological, historical, architectural, geological, and paleontological value or scientific interest. Such sites cannot be altered, excavated, or damaged and material on them cannot be removed without the written consent of the Executive Director of the National Museums and Monuments of Zimbabwe. The law requires that any monument or relic discovered must be reported in writing to the Executive Director of the National Museums and Monuments of Zimbabwe by the discoverer and the owner of the land on which it is found.	There are no significant gaps between the provisions of the World Bank's Cultural Property (OP/BP 4.11) and Zimbabwe uses National Museums and Monuments Act (CAP 25:11).	There are no envisaged impacts on any cultural heritage sites under the Project since project sites are already existing facilities. However, the Project may encounter cultural findings by chance. There will be some minor excavation. This will be done according to the provisions of the Chance Find Procedures outlined in this ESMF. The management of cultural heritage of a country is the responsibility of the government. The government's attention should be drawn specifically to what is known about the cultural property aspects of the proposed project site and appropriate agencies (NMMZ), NGOs, or university departments should be consulted; if there are any questions concerning cultural property in the area, a brief reconnaissance survey should be undertaken in the field by a specialist. The proposed project will not fund sub-projects that will have negative impacts on cultural property.

4.7.2 EHS Guidelines and Zimbabwean Emission Standards

This section presents the gaps analysis between the Zimbabwean Emission Standards and EHS Guideline values This gap analysis shows that the EHS guidelines are generally more stringent that the Zimbabwean Air Emission standards. In this case the project will apply the EHS guidelines.

Table 4-9 EHS Guidelines and Zimbabwean Emission Standards

POLLUTANTS	UNITS	EHS GUIDELINE VALUE	ZIMBABWE EMISSION STANDARD
Total Particulate matter (PM)	mg/Nm3	10	100
Total organic carbon (TOC)	mg/Nm3	10	30
Hydrogen Chloride (HCl)	mg/Nm3	10	30
Hydrogen Fluoride (HF)	mg/Nm3	1	----
Sulphur dioxide (SO2)	mg/Nm3	50	50
Carbon Monoxide (CO)	mg/Nm3	50	100
NOX	mg/Nm3	200-400(a	150
Mercury (Hg)	mg/Nm3	0.05	----
Cadmium + Thallium (Cd + Tl)	mg/Nm3	0.05	----
Sb, As, Pb, Cr, Co, Cu, Mn, Ni and V	mg/Nm3	0.5	----
Polychlorinated dibenzodioxin and dibenzofuran (PCDD/F)	ng/Nm3TEQ	0.1	----

5. ANTICIPATED ENVIRONMENTAL AND SOCIAL IMPACTS OF THE PROJECT

5.1 INTRODUCTION

Potential impacts will be associated with the following HSDSP AF-(V) activities:

- Rehabilitation, or minor civil works at Health Facilities,
- Refurbishments of COVID 19 Isolation centres,
- Supply of diagnoistic kits for laboratories,
- Installation of water tanks and basic sanitation (flush/pour flush to piped sewer system, septic tanks, pit latrines, ventilated improved pit latrines, composting toilets or pit latrines with slabs),
- Provision of supplies at isolation centres such as wash and utility equipment, cleaning materials and linen for public health facilities.

It is expected that any potential negative environmental and social impacts associated with the proposed HSDSP AF-(V) activities and sub-projects will be localized and of short-term duration and can be significantly mitigated through adequate planning and implementation of the ESMP.

With regards to the rehabilitation of existing infrastructure, potential negative impacts are likely to be related to minor impacts on air such as dust and water sources (if not managed properly) which may eventually affect the natural environment as well as human health. Considering that the main activities of the proposed program will be conducted within the footprint of existing institutions, some of the indirect impacts will be related to public nuisance, including disruptions of public access, disruptions of traffic, noise, and dust emissions, as well as health and safety issues that may be experienced by workers in the healthcare facilities.

Activities under Component 1, 2 and 4, which will support the strengthening of health systems together with the COVID-19 emergence response, will result in the increase of health services utilization which will, in turn, lead to increases in the generation, handling and disposal of health care waste streams. Therefore, the issues of concern remain the same as in AF IV, i.e., related to management of infectious healthcare waste and the occupational health and safety of workers coming into contact with the waste and illnesses including the new COVID-19.

Expected environmental risks would be related to the handling, transportation, treatment, and disposal of hazardous medical waste, including infectious waste, pharmaceutical waste, chemical waste such as formaldehyde[9] and its waste, ash from incinerators and sharps. Potential impacts are expected to be site-specific, reversible and can be managed through established and proven

[9] In the Medical field formaldehyde is used for disinfection, sterilization, and preservation of preparations. It is an active gas against all micro-organisms except at low temperature (<20°C); This disinfecting product is recommended for Hepatitis and Ebola virus (but not for HIV/AIDS). The risk associated with formaldehyde is that it can cause cancer. in those applying it. This risk will be avoided by use of proper PPE, washing facilities and the fact that hazardous materials and wastes will be handled according to occupational health and safety guidance provided in the General EHS Guidelines.
Challenges of this system is that the disinfected wastes still need other methods of final elimination. This method gives highly efficient disinfection in good operating conditions, and some chemical disinfectants are relatively inexpensive.

mitigation measures, including instituting the project Infection Control and Waste Management Plan (ICWMP).

Taking into consideration the proposed project activities, the potential environmental and social impacts were identified through desk study and a comprehensive stakeholder consultation process. The following is an analysis of the anticipated environmental and social impacts of the project:

5.2 ENVIRONMENTAL RISK/IMPACT ANALYSIS

5.2.1 Key Environmental Risks

Include:

(i) Environmental degradation from construction waste emanating from refurbishments, the installation of water tanks and basic sanitation (flush/pour flush to piped sewer system, septic tanks, pit latrines, ventilated improved pit latrines, composting toilets or pit latrines with slabs),

(ii) OHS risks for anyone working on refurbishment (including exposure to asbestos) and/or health staff and community safety, including accidental contact with infectious waste and the risk of COVID-19 spreading among health care workers. Poor practices during provision of medical services, blood testing, analysis of samples without proper protective equipment would pose a high risk of infection and possible mortality of healthcare workers,

(iii) Hazardous laboratory and medical waste (including infectious materials, liquid effluents, reagents, etc.) generated from health facilities, hospitals, labs, quarantine, and screening posts. Improper handling, managing, transporting, treatment and disposing of these waste streams pose health and safety risks to health care workers, patients and the public in general from infectious materials, COVID-19 infected waste, radiological waste (from x-rays and the like) and other general waste,

(iv) Incinerators are not fenced/not functional i.e., not well protected, which becomes a risk to the public. (Each Health Care facility should have its own treatment facilities, including trained operators.)

(v) Infectious waste generated from the implementation of COVID 19 response programme, including waste from menstrual health kits, waste from testing kits, masks, etc. (mitigation in ICWMP).

(vi) Lack of proper segregation of waste at source and non-availability of on-site treatment and disposal of the waste can pause risks to waste handling staff.

5.2.2 Environmental Impact Analysis - Planning Phase

(i) Physical Restrictions on building space.

The main impacts related to health and safety during the planning phase is mostly related to the design of refurbishments/renovations of health facilities, Isolation centres, amongst others. All activities will be conducted within the footprint of the existing government facilities/grounds and no new land will be acquired or accessed and most planning must deal with internal refurbishments.

It is therefore necessary that the following safety measures are taken into consideration:

- availability of fire extinguishers and/or fire alarm systems and appropriate storage areas for chemicals,
- Investigate presence of hazardous and flammable materials to reduce risks,
- Investigate presence of asbestos containing materials (ACM),

- Investigate presence of obsolete chemicals, drugs, equipment, etc,
- Local inhabitants and workers should be informed of all safety measures,
- Plan the signals and the necessary signage to be placed close to potential areas of danger.

5.2.3 Environmental Impact Analysis – Construction Phase

Environmental degradation during the Construction implementation phase will emanate from the following construction works, installations and operations:

- Refurbishments of health care facilities,
- Installation of water tanks,
- Installation of basic sanitation (flush/pour flush to piped sewer system, septic tanks, pit latrines, ventilated improved pit latrines, composting toilets or pit latrines with slabs),

.

(i) Soil and Land Degradation

Although the minor construction work (essentially small-scale alterations) will be limited to the footprint of existing infrastructure, some projects may involve works that will expose soil to erosion, conduct minor excavation, compaction or deterioration of the soil structure which will potentially decrease or decrease the drainage of the areas. This could generally result in soil erosion, and generation of dust.

Furthermore, the risk of accidental discharge of hazardous products like paint, leakage of hydrocarbons, oils or grease from machinery constitutes potential sources of soil and land pollution.

Soil and Land Degradation will be minimized through adoption of this ESMF's ESMP (see Table 5-3) that details suitable mitigation and management measures to be taken.

(ii) Construction Waste

Activities at construction sites will produce a small amount of construction wastes such as demolition debris, excavated soils, cement bags, paint drums, brick and concrete rubble, scrap metal, broken glass, timber waste asbestos containing materials and other debris. This debris could pollute the environment, obstruct the public, the movement of the workers and vehicles as well as affect the aesthetics of the environment if not effectively managed.

Of great concern is the asbestos waste and asbestos containing materials from demolition activities. The asbestos hazards should be identified, and a risk management approach adopted that includes disposal techniques and end-of-life sites. The guidance for prevention, minimization, and control of impacts from asbestos or asbestos containing Materials (ACM) derived from the General EHS and Good Practice Note: Asbestos: Occupational and Community Health Issues (World Bank Group May 2009) is outlined in Appendix 12:

Smaller scale impacts will be generated from the upgrading, renovation and installation of WASH facilities. The WASH activities will include at least one water tank and three toilets installed per sub-project. The longer-term issue will be to ensure that the WASH facilities installed are properly maintained and that their waste is properly handled to avoid small-scale pollution.[10]

[10] Wash facilities at the health care facilities do not need to be registered when they get constructed. However, they are inspected on a quarterly basis, together with the whole health Care facility by the Environmental Health Depart of MoHCC.

(iii) Pollution of Ambient Air

Air quality will be impacted by emissions from vehicles, building equipment and released particulate matters (dust). Notably since the project is expected to rely upon incineration to dispose of healthcare hazardous waste, there will be emissions. Incinerator emissions may contain POPs. POPs can arise from incompletely burnt hazardous waste, during cooling of combustion gases, and from hazardous waste contaminated with POPs, e.g., activated carbon filters used for flue gas cleaning in combustion installations. These POPs are not only emitted with the flue gases at the stack, but are also found in the incineration residues, predominantly in the fly and boiler ashes and in the flue gas cleaning residues. The challenge of hazardous waste incineration is to destroy POPs in the waste as completely as possible, while minimizing the formation and release of POPs that form during cooling of combustion gases.

Demolition to modify buildings can lead to cement dust which can affect workers, patients, and staff. Deteriorated indoor air quality will be of critical effect to especially asthmatic construction workers, and patients, with either minor or severe health impact depending on level and duration of exposure.

Pollution of Ambient Air can be minimized through adoption of this ESMF's ESMP (see Table 5-3) that details suitable mitigation and management measures to be taken, institution of dust suppression measures, as well as use of suitable clothing and protective equipment.

(iv) Pollution of Ambient Water

Water quality will be impacted by wastewater discharges from the refurbishment activities. These will include mainly rainwater run-off from the health facility sites. The discharge of this wastewater into surface waters will impact on water quality by causing changes to its physical, chemical, and biological properties. *Pollution of Ambient Water* can be minimized through adoption of this ESMF's ESMP (see Table 5-3) that details suitable mitigation and management measures to be taken.

Given the possibility of generation of waste/spoil that will be generated, it is likely that the waste will be stockpiled on roadsides and in the health facilities premises. If it is not properly contained, rains could carry it along with runoff into surface waters, leading to increased turbidity and siltation.

(v) Temporary Visual Intrusion

Construction activities will require material, equipment, and barriers (to prevent unauthorized individuals from injuring themselves and disturbing works) at the health facilities. Since facilities under renovation may not restrict public access, these activities and materials thereof will cause temporary visual intrusion at all sites. This may be exacerbated by the contractor setting up camp on site. Camp accommodation for workers is not expected to be large and so this should not be a big or long-term concern. For these minor works an average of five (5) people may need to be accommodated on site.

Rehabilitation and upgrading of health care facilities, and other possible facilities will change the aesthetics of the project areas. Contractors will be required to restore any extraction or other altered sites to avoid leaving marred landscapes.

5.2.4 Environmental Impact Analysis – Implementation Phase

Environmental degradation during the Construction implementation phase will emanate from the following construction works, installations and operations:

- Increased Health care Service Provision,
- Supply of Resources to laboratories.
- Increased Laboratory testing for COVID - 19 diagnosis,
- General COVID - 19 response operations,

(i) Healthcare Waste

Project activities generate healthcare waste which contains materials both hazardous to humans and the environment. The project ICWMP contains more details on this. Incinerators which are used to dispose of the infectious waste, will yield products such as fly ash, bottom ash and liquid effluents from flue gas cleaning which are also hazardous waste as they may contain high concentrations of POPs (Persistence Organic Pollutants) which can pollute the air, waterways and other areas if not managed appropriately.

(ii) Increased Generation of Health Care Waste

As much as HSDSP AF-(V) will not support the purchase of such medical materials as sharps, it will enhance the Health Delivery system in general causing the facilities to use more medical supplies and generate more health care waste such as sharps, infectious and non-infectious waste mostly due to:

- Increased referrals to health centres resulting in increased utilization of the health centres with concomitant generation of more health care waste,
- The increased activities and capacitation of CHW will result in them attending to more home-based patients, resulting in more home-based health care waste generation,
- Strengthening pharmaceutical management will result in more drugs being available resulting in more pharmaceutical waste generation including obsolete drugs.

The project will also support the purchase of PPE and Ventilators at isolation centres, PPE at 104 hospitals (mandatory wearing of masks), and Gene Xpert Cartridges for PCR test to diagnose COVID-19 for ten (10) Laboratories and provision of menstrual health kits. This kind of support will result in increased generation of clinical and infectious waste, which will need to be managed carefully to prevent public health risk and environmental impacts. Increased generation of HCW will be mitigated by instituting the requirements of the project ICWMP.

The health facilities and laboratories will generate increased amount of waste, such as infectious sharps, infectious wastewater and increased incinerator usage resulting in toxic emissions and ash from incompletely combusted clinical waste which may contain high levels of POPs. These will need to be managed carefully to prevent public health risk and environmental impacts by implementing the requirements of the project ICWMP. Waste handlers and practitioners must be provided with sufficient and appropriate PPE which must include face masks and eye protection (especially for cleaning of hazardous spills), and respirators (for spills or waste involving toxic dust or incinerator residue).

5.2.5 Potential Environmental Impacts

Table 5-1 Potential Environmental Impacts

REF:	PARAMETER UNDER CONSIDERATION		
	CATEGORY	**CAUSE**	**IMPACT**
5.3.2	**Planning Phase**		
(i)	Physical Restrictions on building space.	● All refurbishment activities restricted to the footprint of the existing government facilities/grounds ● Project activities will not acquire any new land ● most refurbishments will be inside existing buildings.	● presence of hazardous and flammable materials ● presence of asbestos Containing Materials (ACM) ● presence of Obsolete Chemicals, drugs, equipment, etc
5.3.3	**Construction and Operation Phase**		
(i)	Soil and Land degradation.	● minor construction work (essentially small-scale alterations) may expose soil to erosion, compaction, or deterioration of the soil structure which ● Accidental discharge of hazardous substances such as fly ash, bottom ash from incinerators.	● decrease or increase the drainage of the areas ● soil erosion, ● generation of dust. ● Soil and water pollution.
(ii)	Construction Waste	construction wastes will include: ● demolition debris, ● excavated soils, ● cement bags, ● paint drums, ● brick and concrete rubble, ● scrap metal, ● broken glass, ● timber waste and other debris	● pollution of the environment, ● obstruction of the public, and the movement of the workers and vehicles ● affect the aesthetics of the environment if not professionally managed.
(iii)	Pollution of Ambient Air	● emissions from vehicles, ● emissions from building equipment and released particulate matters (dust). ● cement dust from demolitions. ● emissions from incinerators	● Pollution of air ● Deteriorated indoor air quality. ● Increases in bronchial disorders ● Impaired Visibility on the roads
(iv)	Pollution of Ambient Water	▪ wastewater discharges from the refurbishment activities ▪ Erosion processes introduce pollutants and particulates into the water. ▪ rainwater run-off from the health facility sites ▪ liquid effluents from flue gas cleaning of incinerators are a hazardous waste	▪ discharge of this wastewater into surface waters impacts on water quality by causing changes to its physical, chemical, and biological properties ▪ Effluent pollutes soil and water resources ▪ Littering and indiscriminate dumping of solid waste pollutes land and water resources ▪ Poisoning of aquatic and inland ecosystems. ▪ Loss of ordinary use of water.
(v)	Temporary Visual Intrusion	● Rehabilitation and upgrading of facilities need materials to be stored at site.	● Change of the aesthetics of project area ● Scars from building material extractions.
(vi)	Increased generation of Health Care waste	● Use of more medical supplies by the enhanced Health Delivery system ● increased utilization of the health centres ● increased home-based patients. ● Availability of more drugs. ● Increased use of PPE	● Generation of more health care waste such as sharps, infectious and non-infectious waste, and toxic fly ash. ● more pharmaceutical waste generation including obsolete drugs. ● Increased PPE waste generation. ● increased generation of clinical and infectious waste.

5.3 SOCIAL AND HEALTH RISK/IMPACT ANALYSIS

As stated above, the project is classified as category B as it will continue to support activities that are aligned with the parent project with some modifications based on lessons learnt during implementation and fund new activities on COVID-19 emergency preparedness and response. Some social risks and impacts are significant; however, they are considered temporary, predictable, and readily managed through project design features and mitigation measures.

Need for a Grievance Redress Mechanism

The potential impacts will infringe on people's rights and they may be aggrieved in one way or another. To address this a grievance redress mechanism has been developed for the project.

The current project GRM is based on both MOHCC conflict-resolution mechanisms as well as project-based steps to ensure that beneficiaries and all stakeholders have opportunities and means to raise their concerns and/or provide suggestions regarding project-related activities. In addition, as part of the COVID-19 response, the MOHCC has established an EOC using a toll-free number to report suspected cases and grievances can be reported through provincial call centres.

For AF-V, the current Grievance Redress mechanisms will be improved to integrate GBV-sensitive measures, including multiple channels to initiate a complaint and specific procedures for SEA, such as confidential and/or anonymous reporting with safe and ethical documenting of GBV and SEA cases. It is important that the project links client satisfaction surveys with the GRM. The current COVID-19 response -Toll Free Number is 2019 and can be used for GRM issues.

5.3.1 Key Social Risks

There are several key social risks which include:

(i) **Enhanced community transmission and exposure of health care workers, health care mobilisers and community workers to COVID-19** due to non-adherence to public health guidelines and lack of/or poor management of PPE,

(ii) **Risks to vulnerable Groups:** Vulnerable groups include people with chronic conditions/disabled, poor people, migrants, the elderly and, disadvantaged sub-groups of women, Indigenous Peoples (IPs). They face several risks which include exclusion from consultations, difficulty to access services, potential displacements, etc,

(iii) **Handling of Project and Personal Information** will cover (i) general project information which must be shared with all stakeholders for the smooth running of the project and (ii) handling and storage of Personal data collected in the process of project implementation in COVID 19 response, (iii) misinformation in social media networks related to COVID-19,

(iv) **Exclusion of disadvantaged groups in consultations:** vulnerable groups are at risk of being left out in the consultation processes and hence in the implementation of the projects. There is need for representation of vulnerable groups in different structures e.g., HCC, Ward committee, CHWs so that their voices are heard.

(v) **Disruptions from Construction Activities** will include disruptions of utilities that may be caused by the contractors, temporary disruption of health care services as sections of the health facility is cut off for refurbishments, Occupational Safety and Health of the construction workers and impacts of construction activities on patients, staff, and other stakeholders.

5.3.2 Social and Health Impact Analysis - Planning Phase

(i) Project Timing

Staff at health care facilities had questions about the timing of project implementation. Specifically, staff expressed concerns about expectations as whether and when project activities would occur. Similarly, most stakeholders do not know exactly what will happen and when it will happen. They are holding the whole process with suspicion as only senior MoHCC personnel know what is happening, thus raising the need for sensitization meetings in the project areas so that communities become aware of what is going on.

5.3.3 Social and Health Impact Analysis – Construction/Implementation Phase

(i) Enhanced Community Transmission and Exposure of Health Workers to COVID-19

a) Potential Risks of healthcare workers

The project will also directly support measures to ensure that healthcare workers and the public at large do not pose a risk to others, through training and provision of PPE, as well as in terms of their social behaviours. The national Codes of Ethics for healthcare workers will be used to promote respectful workplaces, and any potential engagement of community workers who may be engaged for contact tracing.

b) Availability, adequacy and poor practices in PPE use

Availability, adequacy and poor practices in PPE use should also apply to all care levels, (Central, Provincial, District hospitals and Clinics). There is need to strengthen practices through trainings on the rational use of PPE at all levels of care. Further, Health care workers should put on scrubs at clinical settings which should be washed and stored at the facility to protect the public from contamination.

(ii) Risks to vulnerable Groups

a) Difficulties in Access to Services by Vulnerable Social Groups

Difficulties in access to services by vulnerable social groups through Exclusion in consultations, (i.e. people with chronic conditions/disabled, poor people, migrants, the elderly and, disadvantaged sub-groups of women, Indigenous Peoples (IPs)).

(iii) Handling of Project and Personal Information

a) Personal Data Protection

Possible personal data protection concerns which may arise in relation to the collection, storage or use of personal data. Large volumes of personal data, personally identifiable information and sensitive data are likely to be collected and used in connection with the COVID-19 response under circumstances where measures to ensure the legitimate, appropriate and proportionate use and processing of data may not feature in national law or data governance regulations, or be routinely collected and managed in health information systems.

b) General Project Information

Full participation of key stakeholders during project preparation and implementation, is important to the successful implementation of the project. Thus, the AF-V project will ensure that information is meaningful, timely, and accessible to populations that are most at risk (such as women, youths, persons living with disabilities, and elderly people densely

populated areas), and contribute to strengthening the capacities of community structures in promoting prevention messages in the community.

Component 2 is focused on complementing efforts to ensure communication is strengthened in communities, enhancing provision of clear information related to risks and prevention measures. Proper communication and advocacy will result in social and behaviour change and health delivery strengthening down to village level by changing the perceptions of the implementors and villagers through various training programmes.

c) Misinformation in Social Media Networks Related to COVID-19

Misinformation in social media networks related to COVID-19 and stigma for those who will be quarantined or admitted to isolation or treatment centres, which may contribute to propagate contagion, which can be countered by contnious consultations, publicising and communication of the correct information through various media (see Table 5-1, Component 4 b). This can be batressed with correct handling of project and personal information, and tracking of media every now and then to correct myth and misconceptions on how to deal with the pandemic. Call centres should be established, be well manned and provided with the necessary tools (e.g., tablet/phone dedicated for that).

(iv) Disruptions from Construction Activities

a Disruption of Utilities Service

The demolitions and refurbishment activities may cause temporary disruptions of utility services such as electricity, communication, and water. Such disruptions may inconvenience the communities in the vicinity of the centres.

b Temporary Disruption of Health Care Services

Since facilities under renovation will not be closed, they will experience shortages of working space. Thus, modifications of rooms in which health care services is provided may entail moving patients or equipment from one area or room to another. This may cause temporary disruption of the health care delivery programmes.

c Occupational Safety and Health

The movement of trucks to and from the site, the operation of various equipment and machinery and the actual refurbishment activities will expose the workers to work-related accidents and injuries. Pollutants such as dust and noise could also have negative implications for the health of workers. There could be increased risk of work-related accidents as a result of lack of use of personal protective equipment by workers during the construction phase. Any cases of work related injuries or death must be reported to the World Bank with immediate effect such as within 24 hours of occurrence.

However, projects can be implemented without any significant risks and impacts, provided that the Health and Safety requirements stated are implemented.

d Impacts of Construction Activities on Patients, Staff, and Other Stakeholders

Refurbishment work undertaken in the same buildings having patients and staff has potential to cause injuries to the occupants. At all sites, renovation works will have the following potential hazards to patients and staff:

- Exposure to asbestos containing materials, (Old buildings with asbestos roofs),
- Falling from tripping on building materials,
- Noise and vibrations during demolition,
- Injury from falling or flying debris when demolishing walls,
- Cracking of existing structures from vibrations,
- Spillages and dust during transportation of materials.

The safety of the local population may be at risk during construction activities. Pollutants such as dust and noise could also have negative implications for the health of the near-by communities. Camp accommodation for workers is not expected to be large and so this should not be a big or long-term concern. For these minor works an average of five (5) people may need to be accommodated on site therefore, labour influx related issues are not expected to be significant or important.

5.3.4 Potential Social Impacts

Table 5-2 Potential Social Impacts

REF:	PARAMETER UNDER CONSIDERATION		
	CATEGORY	**CAUSE**	**IMPACT**
5.4.2	**Planning phase impacts**		
(i)	Project Timing	● Limited Stakeholder Involvement ● Inadequate dissemination/sharing of information ● Unclear roles and responsibilities ● Predominance of the top-down approach. ● Negative perception ● Lack of transparency from the Authorities ● Lack of proper timelines for the different phases of the project ● Dragging the planning phase too long	● Low chances of success and sustainability ● Failure to take up ownership of the project ● Anxiety and anticipation Limited cooperation ● Suspicion and hence concealing important of information
5.4.3	**Construction Phase**		
(i)	**Enhanced community transmission and exposure of Health Workers To COVID-19**		
(a)	Potential Risks of healthcare workers	● Staff executing their duties. ● Engagement with Community workers.	● Community transmission of diseases ● Transmission of diseases at health care centres.
(ii)	**Risks to vulnerable Groups**		
(a)	Difficulties in Access to Services by Vulnerable Social Groups	● Exclusion from consultations of disadvantaged groups	● Failure to access services. ● Exclusion from essential services. ● long-term hardship, impoverishment, and social unrest among the affected community
(iii)	**Handling of Project and Personal Information**		
(a)	Personal Data Protection	● collection, storage or use of personal data ● legitimate, appropriate and proportionate use and processing of data may not feature in national law or data governance regulations.	● Abuse of personal information and data.
(b)	General Project Information	● Limited sharing of project information. ● Information not readily available to populations that are most at risk.	● Weak community structures to promote prevention messages

REF:	PARAMETER UNDER CONSIDERATION		
	CATEGORY	**CAUSE**	**IMPACT**
(c)	Misinformation in Social Media Networks Related to COVID-19	• social media networks spreading various information about COVID-19.	• stigma for those infected by COVID 19. • Lack of correct information of how to deal with the pandemic.
(iv)	**Disruptions from Construction Activities.**		
(a)	Disruption of Utilities Service	• demolitions and refurbishment activities	• temporary disruptions of utility services such as electricity, communication, and water • inconvenience the communities and the facility too.
(b)	Temporary disruption of Health Care Services	• blocking sections of the facility under renovation.	• shortages of working space.
(c)	Occupational Health and Safety Issues	• Weak technical capacity and/or negligence on operation of vehicles and machinery • Lack or inadequate use of safety gear may also contribute to accidents that may result in trauma and other casualties.	• Temporary and permanent physical injuries • Bronchial diseases from dust. • Loss of life
(d)	Impacts of Construction Activities on Patients, Staff, and Other Stakeholders.	• Noise and vibrations during works. • Spillages and dust during transportation of materials. • Falling from tripping on building materials. • Falling or flying debris.	• Temporary and permanent physical injuries • Bronchial diseases from dust. • Loss of life • Cracking of existing structures from vibrations.

5.4 CUMULATIVE IMPACTS

The cumulative impact of a project is the total impact arising from the project itself, (under the control of the developer), other activities (that may be under the control of others, including other developers, local communities, government) and other background pressures and trends which may be unregulated. The project's impact is therefore one part of the total cumulative impact on the environment.

In the context of the HSDSP AF (V), several fronts have the potential of improving both from the impact of the project and other driving forces. These include the following:

(i) Improvement of Quality of Care and Utilization of Public Health Facilities

Generally, the RBF approach targets the improvement of the quality of care and the increase of utilization of public health facilities by equipping and training health care workers in the use of the equipment and proper care of patents. The project will positively impact the health delivery programmes through improved quality and diversity of services offered. Improvements of service delivery and installation of equipment will enable currently inefficient facilities to provide improved health care services leading to improved health conditions. The project will also result in the improvement of the health of the populace.

At the same time Government and other international organisations are working on similar initiatives in the concerted fight against the COVID -19 Pandemic. All these efforts will result in a cumulative improvement in the quality of care and the increase of utilization of public health facilities

(ii) Improvement of Health and Hygiene

The hygiene standards will be raised by the installation of the minor civil sanitary works and systematic involvement of WASH issues in the programme. Provision of water, sanitation and hand washing stations at health facilities and COVID-19 Isolation centres will greatly improve health and hygiene at these centres. This coupled with improved running of the facilities through the RBF approach will also improve aesthetics of the Health Facilities.

At the same time Government and other international organizations are spreading the same message of hygiene improvement, washing of hands, sanitizing hands, and surfaces etc. as they fight to control the spread of the COVID 19 virus. All these efforts will result in a cumulative improvement in the health and hygiene of the populace.

(iii) Improvement in Livelihoods and Local Economies

Improved health care delivery will improve the health of the children, mothers, and adolescents, resulting in increased productivity and household incomes and ultimately to long-term benefit of improved local economies. This improvement will be compounded by the efforts of Government and other development partners who are fighting to improve the health of the population which is under onslaught from the COVID pandemic.

5.5 ENVIRONMENTAL SOCIAL MANAGEMENT PLANS (ESMPs)

The proposed mitigation measures for the Zimbabwe HSDSP AF-(V) Project (Tables 6-1), provide guidelines for the management of potential environmental and social aspects at all possible sub-project sites. The mitigation or enhancement measures will reduce the negative impacts and enhance the positive impacts. The identified impacts and their mitigation measures will be used in the preparation of site-specific Environmental and Social Management Plans (ESMP) and a Template for Environmental and Social Management Plan is included as an Appendix 6. Site-specific ESMPs will be developed by the Provincial/District Technical teams under the oversight and guidance of the PIE Environmental Specialist (see section 1.7 and 6.1).

Every sub-project that will be funded under HSDSP AF-(V) will be screened for environmental and social impacts (Section 6.3.1, Environmental Screening) and may require a site-specific ESMP. Appendix 6 presents templates for ESMP formulation. Generally, most of the sub-projects will adopt the generic ESMP developed here, but in case there will be a sub-project that will require the development of a site-specific ESMP or any other safeguard instrument, the instrument may require a “no objection” from the World Bank and will be publicly disclosed once completed.

The site-specific ESMP will capture the potential impacts, mitigation, monitoring and institutional measures to be taken during the project implementation to avoid or eliminate negative environmental impacts. For each impact, mitigation measures should be identified and listed. Estimates are made of the cost of mitigation actions.

Table 5-3 outlines the generic ESMP for this ESMF. It took into consideration the potential adverse impacts of the Project, which include direct impacts on sites, the generation of solid and liquid waste, the generation of medical waste and the disposal thereof, as well as occupational risks faced by workers in the healthcare facilities or during the minor civil works that will be done.

Table 5-3 Generic ESMP of the HSDSP AF-(V). – by Project Component

Table 5-3 Generic ESMP of the HSDSP AF (V) – by Project Component				
PROJECT ACTIVITIES / PROJECT COMPONENT	RISK/ IMPACTS	MITIGATION MEASURES	RESPONSIBILITY FOR IMPLEMENTATION	MONITORING INDICATORS
For All Components: For all project activities OHS COVID-19 risks will be mitigated by provision of PPE (including hand sanitizers and masks, etc. as necessary) and promotion and observation of COVID-19 protocols to halt the spread.				
Component 1. Results-Based Financing in Delivery of Packages of Key Maternal, Child and Other Related Health Services (RMNCAH-N)				
Sub-Component 1 a: RMNCAH-N: Rural RBF				
The Sub-project will support improved quality and service delivery in RMNCAH-N using a multisectoral approach: a) funding to continue to support rural RBF in the 18 project districts b) The RBF package expanded from RMNCAH-N, TB, and HIV to include NCDs such as hypertension at primary level and diabetes at secondary care level. c) AF will continue to finance performance contracts with DHEs and PHEs, using expanded performance indicators.	• Leaving out some health staff from incentives (Bonus payments) and not applying the incentives calculator properly so that there is fair distribution of the incentives, inducing lack of participation and poor facility performance. • Health staff may not get all the agreed incentives – the 50% That they should receive may not all go to them. • Subsidy payments not paid on time	• Bonus payments should include all health facility personnel whether civil servants, health partners and CHW. • Quality payments must always be paid on time.	• Ministry of Health • HSDSP AF-(V).	• Bonus Payments covering all staff
	• Increased generation of medical waste.	• Medical waste to be properly disposed of in accordance with the project Infection Control and Waste Management Plan (ICWMP). • Each facility must draft an approved medical Waste Management Plan before beginning any medical waste generating activities financed by the project in accordance with the ICWMP. The Medical	• Health Facility	• Segregation at source • No accumulation of Waste • Functioning incinerator • Use of proper PPE

	Table 5-3 Generic ESMP of the HSDSP AF (V) – by Project Component				
	PROJECT ACTIVITIES / PROJECT COMPONENT	RISK/ IMPACTS	MITIGATION MEASURES	RESPONSIBILITY FOR IMPLEMENTATION	MONITORING INDICATORS
			Waste Management Plan to be approved by the PIE and World Bank.		
	Sub-Component 1 b: Rural Expanded Supply Side Community RBF				
	a) Expanded Supply Side Community (ESSC) RBF in line with the Community Health Strategy in four rural districts. b) Community level mobilization activities incorporated in their Operational Plan.[11] Key Community interventions include the following: (i) WASH, (i) nutrition, breastfeeding, growth promotion and monitoring, and Vitamin A supplementation. (ii) early pregnancy detection and referral. (iii) reduction of adolescent pregnancies through communication for behavioural change; and (iv) early reporting and community psychosocial support for	• Exclusion of the current CHW from the project due to introduction of monetary incentives. • Excessive demands on time availability of limited numbers of CHW. • OHS threats/risks to staff from COVID	• Ensure that all current CHW are not excluded from the project and are accordingly compensated. • Enhance the capacity of the CHW and medical personnel to monitor and assess health, nutrition status by identification of appropriate indicators, and installing of monitoring and evaluation system.	• Health Facility	• CHWs fully participating • Health and Nutrition status monitored. • Use of proper PPE and other necessary supplies such as sanitizer, etc.
		• Increased generation of health care waste from Health care centres and home-based care. • Consumption of contaminated drinking water and accessing unsafe sanitation services can have negative impacts on human health and the environment. • Polluted water from naturally occurring chemicals such as arsenic, industrial waste and infectious pathogens can	• Adhere to the Requirements of the Infection Control and Waste Management Plan (ICWMP) prepared for this project for clinical waste management. • Capacitate CHW to promote access to safe drinking water including regular testing; quarterly for borehole sources and monthly for surface water sources.	• Health Facility	• No accumulation of waste • Waste Segregated at source. • Home based Health Care waste handled properly

[11] The community RBF will be piloted in four (4) districts out of the eighteen (18) districts. The average number of village health workers in each of the 18 districts has been estimated. The actual districts have not yet been selected. The average number of health facilities per district were also determined.

	Table 5-3 Generic ESMP of the HSDSP AF (V) – by Project Component				
	PROJECT ACTIVITIES / PROJECT COMPONENT	RISK/ IMPACTS	MITIGATION MEASURES	RESPONSIBILITY FOR IMPLEMENTATION	MONITORING INDICATORS
	victims of SGBV including linkages/referrals to care. All interventions will incorporate gender mainstreaming through involvement of both females and males in the communities.	result in chronic health impacts – like acute poisoning, immune suppression, disability, and mortality. • Microbial pollutants from sewage cause waterborne diseases such as typhoid fever, cholera, and diarrheal diseases. •	• Capacitate CHW to promote access to safe sanitation services • Access to hand washing facilities • Proper siting and handling of sanitation waste during operation to avoid contamination of natural rivers.		
	Sub-Component 1.c: RMNCAH-N: supply side RBF for provincial and central hospitals focusing on quality of care				
	a) RBF in two central hospitals and 8 provincial hospitals, focusing on quality of care. A hospital quality checklist will be used to balance between: (i) structural quality. (ii) clinical processes; and (iii) patient experience, while also prioritizing selected indicators to reduce the risk of COVID-19 transmission.				
		• During the epidemic, COVID-19 risks to staff and the public.	Provision of PPE, promotion and observation of COVID-19 protocols to halt the spread. •	• PIE	Sufficient PPE provided
		• Increased generation of health care waste from Health care centres.	• Adhere to the requirements of the **Infection Control and Waste Management Plan (ICWMP) prepared for this project** for clinical waste management. • Each facility must draft an approved medical Waste Management Plan before beginning any medical waste-generating activities financed by the project in accordance with the ICWMP. The Medical Waste Management Plan to be approved by the PIE and World Bank.	• Health Facility • Contractors	• Waste handling system functional • No accumulation of waste. • Waste Segregated at site • Waste collected regularly

	Table 5-3 Generic ESMP of the HSDSP AF (V) – by Project Component				
	PROJECT ACTIVITIES / PROJECT COMPONENT	RISK/ IMPACTS	MITIGATION MEASURES	RESPONSIBILITY FOR IMPLEMENTATION	MONITORING INDICATORS
	Sub-Component 1.d. RMNCAH-N: Urban RBF				
	This sub-component will continue to support the urban RBF in pilot areas and scale it up to additional municipal health facilities and expanding the package to: (iv) family planning for poor pregnant urban women, (v) vitamin A supplementation for their children 18-59 months old, and (vi) provision of PEP to SGBV affected poor urban women. **(vii)** TA to assess the feasibility of converting the UV pilot into a health equity card (HEC) system to provide a service package focusing on maternal, neonatal and child health and nutrition for the poor.	• An increase in the clinical waste generation in urban health care delivery facilities.	• Facilities to Adhere to the Requirements of the **Infection Control and Waste Management Plan (ICWMP) prepared for this project** for clinical waste management. • Each facility must draft an approved medical Waste Management Plan before beginning any medical waste-generating activities financed by the project in accordance with the ICWMP. The Medical Waste Management Plan to be approved by the PIE and World Bank.	• Health Facility	• Waste handling system functional • No accumulation of waste. • Waste Segregated at site • Waste collected regularly • Proper PPE provided and being used
	Component 2. Management and Capacity Building. This component will finance overall program and project management, supervision and capacity building.				
	Sub-Component 2.a. Management and Capacity Building for RMNCAH-N RBF				

Table 5-3 Generic ESMP of the HSDSP AF (V) – by Project Component				
PROJECT ACTIVITIES / PROJECT COMPONENT	RISK/ IMPACTS	MITIGATION MEASURES	RESPONSIBILITY FOR IMPLEMENTATION	MONITORING INDICATORS

• improve project management capacity of participating ministries: MOHCC, MOFED, Ministry of Public Service, Labour and Social Welfare (MOPSLSW) and other related Government Ministries
• RBF institutionalization and UV scale-up,
• finance equipment and TA to strengthen the referral system.
• development of RMNCAH-N Quality Improvement (QI) Guidelines
• equipping and strengthening postnatal care by developing job aids
• improve health care waste management through development of job aides/guidelines and including key indicators around health workers safety in the quality supportive supervision tools.
• development and operationalization of data capturing tools for community team leaders
• support the Health Information Systems in various ways to improve communication.
	• Minor works infrastructure development impacts and risks include:
	  • for construction, impacts such as dust, noise, nuisance to community, OHS risks to workers, waste generation
	  • for operation, hazardous medical waste generation,
		• Contractors to put in place such measures as dust suppression, proper waste management, use of low noise machinery, cutting off sections of the facility at a time, etc. to minimise any impacts on patients and use of proper PPE. Training of workers in health and safety, provision of first aid kit and other necessary supplies.
		• Proper waste management practices should be maintained including final disposition at authorised sites.
			Health Facility concerned, contractor	• Proper PPE supplied
				Site restoration

	• Indirect increased generation of medical waste, including obsolete drugs • Improvements in Waste management not meeting the increment in clinical waste generation from the improved Health Delivery system	• Medical waste to be properly disposed-off in accordance with the project Infection Control and Waste Management Plan. • Clinical Waste management must be continuously improved, and the requirements of the Infection Control and Waste Management Plan (ICWMP) prepared for this project, adhered to. • Each facility must draft an approved medical Waste Management Plan before beginning any medical waste-generating activities financed by the project in accordance with the ICWMP.	• Health Facility	• Waste handling system functional • No accumulation of waste. • Waste segregated at site • waste collected regularly

	Table 5-3 Generic ESMP of the HSDSP AF (V) – by Project Component				
	PROJECT ACTIVITIES / PROJECT COMPONENT	RISK/ IMPACTS	MITIGATION MEASURES	RESPONSIBILITY FOR IMPLEMENTATION	MONITORING INDICATORS
	health facilities may support communities to carry out minor related works using a share of RBF subsidies generated by CHWs.	• OHS issues of Health workers, cleaners or workers involved in upgrades and installation of new equipment •	• All workers to receive appropriate PPE and safety training • Train all workers on occupational health and safety guidelines and practices to follow during the COVID-19 crisis in line with WB & WHO guidelines.	• PIE • MoHCC. - Environmental Health Dept. • Health Facility • Ministry of Labour	• Number of staff trained in special COVID-19 occupational health and safety guidelines and practices • Availability of suitable PPE for all staff • Number of local workers with health problems • Number of accidents caused by project activities and reported • Number of Safety equipment (PPE) available at construction site for workers
		• Increased workplace COVID-19 infections, gender-based violence, and community conflicts due to continuous interaction with local communities.	• Promote consistent and correct use of PPE, and strengthening the existing GRMs • Implement relevant measures to mitigate potential impacts between the workers and community members i.e., operating two GRMs, one for project workers and other for project beneficiaries to report on issues that concerns them. • Ensure that community workers including communities and vulnerable groups would also be made aware on protocols to adhere to during community interactions such as practicing proper hygiene, masking, other safety	• PIE • MoHCC. • Health Facility	• staff wearing correct PPE, • appropriate GRM in place • Safety precautions being enforced, • Number of PPEs available.

	Table 5-3 Generic ESMP of the HSDSP AF (V) – by Project Component				
	PROJECT ACTIVITIES / PROJECT COMPONENT	RISK/ IMPACTS	MITIGATION MEASURES	RESPONSIBILITY FOR IMPLEMENTATION	MONITORING INDICATORS
			precautions and social distancing measures.		
		Sexual Exploitation and Abuse (SEA)/ Sexual Harassment (SH): Risks of SEA and SH may also increase because of increased interactions between the health workers and community groups during home visits, especially for homes without any male presence.	• The project will train all project workers on GBV, SEA and SH prevention measures and protocols. • Awareness raising will be made on risk of GBV, SEA, SH, and domestic violence and on prevention measures. • Ensure that all staff and community members are made aware of the GRM and how to lodge complaints to through the GRM.	• MoHCC • RDCs • EIA Department	• Number of Staff trained • Number of awareness programmes made •
	Sub-Component 2.b.: Selected Key Health Financing Reforms				
	This new sub-component together with Health Financing TA from the GFF will support implementation of the National Health Financing Strategy especially in providing TA to assist MOHCC with **a)** improving resource allocation and expenditure efficiency and **b)** strengthening domestic resource mobilization in the health sector to help mitigate the significant risks posed by the country's macroeconomic situation	Poses no risk.			

	Table 5-3 Generic ESMP of the HSDSP AF (V) – by Project Component				
	PROJECT ACTIVITIES / PROJECT COMPONENT	RISK/ IMPACTS	MITIGATION MEASURES	RESPONSIBILITY FOR IMPLEMENTATION	MONITORING INDICATORS
	Component 3. Documentation, Monitoring and Verification of Results				
a)	• This component will continue to support monitoring, evaluation, and external verification including counter-verification activities undertaken by the HPA[12] as part of the RBF program. • Operational research and assessments of the HSDSP AF-(V) implementation, ESSC RBF and central hospital pilot projects • strengthen project-related mechanisms for grievance redress (GRM) and stakeholder engagement through provision of TA, equipment, and tools to improve current systems within the MOHCC and the PIE, • project monitoring by national and provincial teams, as well as documentation of most significant changes and lessons and their dissemination using various platforms.	Poses no risk.			
	Component 4. COVID-19 Response				

[12] The HPA of Zimbabwe oversees registration of health institutions and regulates services provided by these institutions.

Table 5-3 Generic ESMP of the HSDSP AF (V) – by Project Component					
PROJECT ACTIVITIES / PROJECT COMPONENT	RISK/ IMPACTS	MITIGATION MEASURES		RESPONSIBILITY FOR IMPLEMENTATION	MONITORING INDICATORS
This new component aims to support the GOZ to prevent the spread of COVID-19, prioritizing infection prevention control while also strengthening the focus on results of the national COVID-19 response**.** It will also enable the country to mobilize surge response capacity through trained and well-equipped frontline health workers and better equipped facilities. The component will finance provisions for emergency response activities targeted at migrant and displaced populations in fragile, conflict or humanitarian emergency settings compounded by COVID-19.					
Sub-Component 4.a. Case Detection, Contact Tracing, Recording, Reporting					
• strengthening COVID-19 surveillance systems including detection, recording, and reporting of cases • development of an electronic reporting tool. • improve laboratory capacity through procurement of Polymerase Chain Reaction (PCR) based laboratory test cartridges.	• Laboratory reagents pose health risks if not managed and stored properly • Health care waste management from testing	a) Apply the requirements of the Project ICWMP ○ Refer to Project ICWMP for further details on management and storage of reagents. ○ Waste management for the COVID-testing conducted with procured lab test cartridges		Ministry of Health and district referral hospitals	• Case detection enhanced • Contact tracing enhance • Proper use of provided PPE
• support epidemiological investigation and contact tracing by ○ procuring and/or repairing motorcycles ○ financing their fuel and repairs, ○ providing performance-based allowances to rapid response teams for effective and efficient contact tracing • Data provision for decision-making through training of health personnel on the Go-data system and provision of tablets for surveillance activities.	• During the epidemic, COVID-19 risks to staff and the public. • Community health and safety aspects during implementation of project.	• Provision of PPE, promotion, and observation of COVID-19 protocols to halt the spread. • Observation of basic protocols: – hand washing, social distancing, management of public gatherings • Observation of the World Bank guidelines of Carrying out consultations during Pandemic situation; -Technical Note: Public Consultations and Stakeholder Engagement in WB-supported operations when there are constraints on conducting public meetings		PIE	• Sufficient PPE provided • Protocols observed

	Table 5-3 Generic ESMP of the HSDSP AF (V) – by Project Component				
	PROJECT ACTIVITIES / PROJECT COMPONENT	RISK/ IMPACTS	MITIGATION MEASURES	RESPONSIBILITY FOR IMPLEMENTATION	MONITORING INDICATORS
		Layout of laboratory does not meet requirements for biosafety in the project Exclusion List, it should not receive project support until the standards are in place.)	• Consider and ensure guidance from WHO laboratory biosafety guidance (including that relate COVID-19**),** eye wash stations, appropriate PPE, etc**.**	Ministry of Health and district referral hospitals	• Bio-safety standards in place
		Community health and safety aspects during implementation of these activities.	Observe basic protocols – • hand washing, • social distancing, • management of public gatherings • re: Bank's guidance: Technical Note: Public Consultations and Stakeholder Engagement in WB-supported operations when there are constraints on conducting public meetings	Ministry of Health and district referral hospitals CHW	• Basic COVID-19 protocols being observed
		Collection of samples and laboratory testing for COVID19 could result in spread of disease to medical workers or laboratory workers, or population during the transport of potentially affected samples.	• Collection of samples, transportation of samples and testing of the clinical specimens from patients meeting the suspect case definition should be performed in accordance with WHO interim guidance laboratory testing for coronavirus disease 2019 (COVID-19) in suspected human cases. Tests should be performed in appropriately equipped laboratories (specimen handling for molecular testing requires BSL-2 or equivalent facilities) by staff trained in the relevant technical and safety procedures. • National guidelines on laboratory biosafety should be followed. For more information related to COVID-19 risk assessment, see specific interim guidance document: WHO interim guidance for	Healthcare facilities, PIU	• Testing and detection enhanced • Use of proper provided PPE.

	Table 5-3 Generic ESMP of the HSDSP AF (V) – by Project Component				
	PROJECT ACTIVITIES / PROJECT COMPONENT	RISK/ IMPACTS	MITIGATION MEASURES	RESPONSIBILITY FOR IMPLEMENTATION	MONITORING INDICATORS
			laboratory biosafety related to 2019-nCoV.The national guidelines include: ○ National Biotechnology Authority (Agricultural Biotechnology products) Regulations, 2018 ○ SI 84 of 2020 Public Health (COVID-19 Prevention, Containment and Treatment) (Amendment) regulations, 2020. • Samples that are potentially infectious materials (PIM) need to be handled and stored as described in project ICWMP in line with WHO document Guidance to minimize risks for facilities collecting, handling, or storing materials potentially infectious for polioviruses (PIM Guidance),. • For general laboratory biosafety guidelines, see the WHO laboratory Biosafety Manual, 3rd edition. • Apply the requirements of the Project ICWMP • Refer to Project ICWMP for further details		
	Sub-Component 4.b: Risk Communication and Community Engagement				
	• This Sub-Component will strengthen interpersonal communication throughout the Health Delivery System including psychosocial support to health care workers and COVID-19 affected persons. • Activities include:	• Rumours and false information in the electronic media causing panic. • Inappropriate information and communication increase social stigma with those who expose or are infected by virus. • Risk of fear and/or stigma towards the virus, which may make people hide	• When developing communication messages about COVID-19, it is important to have social stigma issues in mind and choose language that does not exacerbate stigma. • It is best to not refer to people with the disease as “COVID-19 cases”, “victims” “COVID-19 families” or “the diseased”. It is	MOHCC and PIE	• Health care workers benefit from the psychosocial support. • COVID-19 affected benefit from the psychosocial support • Call centre teams incentivised.

	Table 5-3 Generic ESMP of the HSDSP AF (V) – by Project Component				
	PROJECT ACTIVITIES / PROJECT COMPONENT	RISK/ IMPACTS	MITIGATION MEASURES	RESPONSIBILITY FOR IMPLEMENTATION	MONITORING INDICATORS
	• the development and dissemination of messages, tools, and materials to be used in the current pandemic or emerging infectious disease outbreak. • supporting the MOHCC Mental Health Department to provide multi-channel psychosocial support through call centres, websites, social media, mass media reach: and • providing allowances to national and sub-national call centres teams.	symptoms, avoid getting tested and even reject hygiene measures or wearing PPE equipment (or masks if recommended) • Health workers may suffer stigma, when coming back to their communities, as they may be potential "carriers" • Some groups may be particularly vulnerable to stigma. • OHS risks to health workers.	better to refer as "people who have COVID-19", "people who are being treated for COVID-19", or "people who are recovering from COVID-19". It is important to separate a person from having an identity defined by COVID-19, to reduce stigma. This language should be used throughout all communication materials. • Ensure accurate information about the virus is widely disseminated, and that there is also a focus on people recovered. • When developing communication materials, refer to WHO information on social stigma: https://www.who.int/docs/default-source/coronaviruse/COVID19-stigma-guide.pdf. • Engage social influencers, such as religious leaders, who can help communicate accurate messages and help to reduce social stigma as well as support those who may be stigmatized. Correct misconceptions and provide accurate information. One way to do this could be through District health officials and/or community leaders/officials. They could be trained on the basics of COVID-19 prevention (good hygiene, frequent hand washing, avoid touching face, social isolation measures) and be provided with simple materials in local language. These officials can use this information to inform others in their communities, including		• Information, communication, capacity building and stakeholder engagement • Use of proper PPE and supplies such as hand sanitizer, Face Masks, Aprons, overalls, etc observed and provided

	Table 5-3 Generic ESMP of the HSDSP AF (V) – by Project Component				
	PROJECT ACTIVITIES / PROJECT COMPONENT	RISK/ IMPACTS	MITIGATION MEASURES	RESPONSIBILITY FOR IMPLEMENTATION	MONITORING INDICATORS
			correcting false rumours. Focus should be on prevention as well as on identifying symptoms and how to seek treatment. • Use of PPE and other COVID-19 prevention protocols.		
		Communication materials may not reach the most vulnerable, including the elderly, vulnerable groups and workers from the informal sector, a lot of whom are women, who tend to have lower levels of education, lower incomes and may lack access to reliable information materials.	• Develop clear and concise communication materials and ensure that it is in a format/language that is understandable to all people, in particular the most vulnerable. • When developing communication materials, refer to WHO information on social stigma: https://www.who.int/docs/default-source/coronaviruse/COVID19-stigma-guide.pdf • Use different media (social media, radio, tv) plus engaging existing formal and informal public health and community-based networks (schools, healthcare service providers at local level, etc). Ensure that information is accessible in sign language, braille, illustrations/pictorial and in Sesotho. • Ensure messages relating to COVID-19 reach all groups of people, the most vulnerable (the poor, elderly, women single heads of household, those with a disability, vulnerable groups, any marginalized group). This may include having a multi-faceted approach to consultations and disclosure of information and information sharing, such as by loudspeaker (by community authorities or district health authorities),	Healthcare facilities, PIE	

Table 5-3 Generic ESMP of the HSDSP AF (V) – by Project Component					
	PROJECT ACTIVITIES / PROJECT COMPONENT	RISK/ IMPACTS	MITIGATION MEASURES	RESPONSIBILITY FOR IMPLEMENTATION	MONITORING INDICATORS
			radio, TV, newspapers, WhatsApp broadcast messages, Facebook, SMS, You Tube videos, community announcement, social influencers/religious leaders, etc. • A focus of information materials should be on women, as they tend to be the best avenue of communication for children, disabled and the elderly in the household. • Communication materials must reinforce the positive contribution of health care workers and other essential workers and their need to be supported by community members. • Communication materials should make clear the steps health workers and others are taking to protect themselves against the virus and their use of PPE		
		Social conflicts: May result from false rumours and misinformation, especially for project supported facilities, project beneficiaries, and other services. If stakeholders are not properly consulted, information is not disclosed and people are not informed about their rights, options for grievance redress or project timelines, there could be misunderstandings, conflict, stigma, gender-based violence, false rumours or loss of confidence in the community regarding the project. Misinformation in social media networks related to COVID-19 and stigma for those	• The ESMF's continuous stakeholder engagement strategy will be utilised to continuously consult the stakeholders in the process of implementing the project. • Ensure the continuous consultations on this ESMF include relevant government agencies, NGOs and other organizations working on health and gender, including GBV, as well as vulnerable groups. Ensure women, and women's groups, are targeted during the continuous consultations on the ESMF, as well as information campaigns. • Identify trusted community groups (local influencers such as community leaders, religious leaders, health workers, community volunteers, celebrities) and	Healthcare facilities, PIE	• Dissemination of correct COVID-19 Information to the public. • Peoples' grievances being addressed timeously. •

	Table 5-3 Generic ESMP of the HSDSP AF (V) – by Project Component				
	PROJECT ACTIVITIES / PROJECT COMPONENT	RISK/ IMPACTS	MITIGATION MEASURES	RESPONSIBILITY FOR IMPLEMENTATION	MONITORING INDICATORS
		who will be quarantined or admitted to isolation or treatment centres.	local networks (such as women's groups, youth groups, business groups, and traditional healers) that can help to disseminate messages. Define clear and easy mechanisms to disseminate messages and materials based on community questions and concerns. • Ensure communication materials not only focus on COVID-19 symptoms and hygiene, but also on: ○ coping strategies if there is social isolation, ○ avenues (materials, organizations, hotline) available for mental health, GBV, etc. that may be available. ○ Correction of misinformation on social media by publicising the correct information far and wide.		
	Sub-Component 4.c.: Infection Prevention and Control (IPC).				
	This Sub-component will strengthen the public health system's capacity to minimize infection risks for patients and health personnel.	Incorrect standard or quality of PPE leads to spread of infection to healthcare workers, cleaners, and patients.	• Procure PPE from reputable suppliers, • Use correct specifications for PPE when ordering. • Adhere to procurement guidelines when purchasing PPE.	Ministry of Health and district referral hospitals	• Use of correct standard PPE [15] • Provision of kits is consistent for the

[15] PPE for waste handlers and practioners must include face masks and eye protection (especially for cleaning of hazardous spills), and respirators (for spills or waste involving toxic dust or incinerator residue).

Table 5-3 Generic ESMP of the HSDSP AF (V) – by Project Component					
	PROJECT ACTIVITIES / PROJECT COMPONENT	RISK/ IMPACTS	MITIGATION MEASURES	RESPONSIBILITY FOR IMPLEMENTATION	MONITORING INDICATORS
	It will finance, among others: (i) PPE kits and IPC-related goods for quarantined cases, rapid response teams who conduct contact tracing, and health personnel working in isolation health care facilities and hospitals. (ii) installation of water tanks in selected isolation centres and supplies for handwashing facilities using WHO/UNICEF Joint Monitoring Program (JMP) standards.[13] (iii) basic sanitation facilities using JMP standards[14] in critical areas, and (iv) medical waste management and disposal systems in selected permanent and temporary isolation healthcare facilities as needed.		• Provide the healthcare workers with proper medical personal protective equipment (PPE) including Medical mask, Gown, Apron, Eye protection (goggles or face shield), Respirator (N95 or FFP2 standard), Boots/closed work shoes. Refer to WHO interim guidance on rational use of PPE for coronavirus disease 2019 for further details on the types of PPE that are required for different functions.		Quarantined cases, and rapid response teams
		Soil and Land Degradation: Although construction work will be minor and limited to the footprint of existing infrastructure, mitigation measures are needed for unlikely circumstances of soil disturbances.	• The contractor(s) is responsible for compliance with relevant national legislation with respect to soil and land degradation. • The contractor(s) should implement Good International Industrial Practices (GIIP) and other international guidelines such as the WBG EHS Guidelines.	• Health Care Facility • Contractors	• Level of WASH issue. • Quality of Facility sanitation
		Ambient air quality: Air quality will be temporarily impacted by the construction activities. Interior demolition to upgrade and refurbish healthcare facilities etc, this will generate dust and debris which can affect workers, patients, and staff. Deteriorated	• compliance with relevant national legislation with respect to indoor and ambient air quality. • ensuring that the generation of dust is minimized, and dust suppression measures instituted indoors and outside.	• Health Care Facility • Contractor(s)	Dust levels are below recommended levels in EHS General Guidelines.

[13] Handwashing facilities include a sink with tap water, buckets with taps, tippy-taps, and jugs or basins designated for handwashing. Soap includes bar soap, liquid soap, powder detergent, and soapy water but does not include ash, soil, sand or other handwashing agents.

[14] Improved sanitation facilities are those designed to hygienically separate excreta from human contact and include flush/pour flush to piped sewer system, septic tanks or pit latrines, ventilated improved pit latrines, composting toilets or pit latrines with slabs.

	Table 5-3 Generic ESMP of the HSDSP AF (V) – by Project Component				
	PROJECT ACTIVITIES / PROJECT COMPONENT	RISK/ IMPACTS	MITIGATION MEASURES	RESPONSIBILITY FOR IMPLEMENTATION	MONITORING INDICATORS
		indoor air quality may pose risks to workers and patients, with either minor or serious health impact depending on level and duration of exposure.	• Keep demolition debris in controlled area and spray with water mist to reduce debris dust • Keep surrounding environment (sidewalks, roads) free of debris to minimize dust • There will be no open burning of construction / waste material at the site • There will be no excessive idling of construction vehicles at sites		
		Construction Waste Management: Activities at construction sites will produce construction wastes such as demolition debris, excavated soils, cement bags, paint drums, brick and concrete rubble, scrap metal, broken glass, timber waste and other debris. This debris could obstruct the public, the movement of the workers and vehicles as well as affect the aesthetics of the environment.	• The contractor(s) shall develop and follow a brief site-specific solid waste control procedure (storage, provision of bins, site clean-up, bin clean-out schedule, etc.) before commencement of any financed rehabilitation works. • The contractor(s) shall use litter bins, containers, and waste collection facilities at all places during works. • The contractor(s) may store solid waste temporarily on site in a designated place prior to off-site transportation and disposal through a licensed waste collector. (a) The contractor(s) shall dispose of waste at designated place identified and approved by local authority. Open burning or burial of solid waste at the hospital premises shall not be allowed. It is prohibited for the contractor(s) to dispose of any debris or construction material/paint in environmentally sensitive areas (including	Contractor(s)	Noise levels below limits in EHS General Guidelines Records of waste generated available weekly site inspection reports available,

	Table 5-3 Generic ESMP of the HSDSP AF (V) – by Project Component				
	PROJECT ACTIVITIES / PROJECT COMPONENT	RISK/ IMPACTS	MITIGATION MEASURES	RESPONSIBILITY FOR IMPLEMENTATION	MONITORING INDICATORS
			watercourse). Recyclable materials such as wooden plates for trench works, steel, scaffolding material, site holding, packaging material, etc. shall be segregated and collected on-site from other waste sources for reuse or recycle (sale). Whenever feasible the contractor will reuse and recycle appropriate and viable materials (except asbestos) (b) Waste collection and disposal pathways and sites will be identified for all major waste types expected from demolition and construction activities. (c) Mineral construction and demolition wastes will be separated from general refuse, organic, liquid and chemical wastes by on-site sorting and stored in appropriate containers. (d) Construction waste will be collected and disposed properly by licensed collectors (e) The records of waste disposal will be maintained as proof for proper management as designed.		
		Asbestos Containing Materials (ACM): The risk of accidental discharge of asbestos containing materials (ACM) generated from construction, rehabilitation, or minor civil works. The risk of ACMs during the refurbishment, facility improvement, isolation ward formation and other similar activities is high since most of the old buildings have asbestos roofs and some old	In reconstruction, demolition, and removal of damaged infrastructure, asbestos hazards should be identified, and a risk management approach adopted that includes disposal techniques and end-of-life sites. Techniques for prevention, minimization, and control of impacts from asbestos or asbestos containing Materials (ACM) and guidance from the General EHS and Good Practice Note:	• Health Facility • Contractor(s)	Site inspections, Disposal site records

	Table 5-3 Generic ESMP of the HSDSP AF (V) – by Project Component				
	PROJECT ACTIVITIES / PROJECT COMPONENT	RISK/ IMPACTS	MITIGATION MEASURES	RESPONSIBILITY FOR IMPLEMENTATION	MONITORING INDICATORS
		hospital equipment has asbestos components.	Asbestos: Occupational and Community Health Issues (World Bank Group May 2009) include: • Avoiding the use of asbestos containing materials (ACM) in renovation activities. • Undertaking an asbestos/hazardous products audit prior to/at the beginning of the refurbishment. • If asbestos is located on the project site, mark clearly as hazardous material. • When possible, the asbestos will be appropriately contained and sealed to minimize exposure • The asbestos prior to removal (if removal is necessary) will be treated with a wetting agent to minimize asbestos dust • Use of specially trained personnel to identify and selectively remove potentially hazardous materials (ACMs) in building elements prior to dismantling or demolition, • Repair or removal and disposal of existing ACM in buildings should only be performed by specially trained personnel, following, internationally recognized procedures. (WB, 2007) • If asbestos material is be stored temporarily, the wastes should be securely enclosed inside closed containments and marked appropriately.		

	Table 5-3 Generic ESMP of the HSDSP AF (V) – by Project Component				
	PROJECT ACTIVITIES / PROJECT COMPONENT	RISK/ IMPACTS	MITIGATION MEASURES	RESPONSIBILITY FOR IMPLEMENTATION	MONITORING INDICATORS
			• Managing the treatment and disposal of ACMs according to Sections 1.5 and 1.6 on Hazardous Materials and Hazardous Waste Management, respectively. • Transporting ACM in leak-tight containers to a secure landfill operated in a manner that precludes air and water contamination that could result from ruptured containers. (WB, 2007) • The removed asbestos will not be reused		
		Hazardous Waste: The risk of accidental discharge of hazardous products like paint, leakage of hydrocarbons, oils or grease from machinery constitutes potential sources of soils and land pollution.	• Contractor(s) will ensure proper storage and labelling of hazardous materials. • Temporarily storage on site of all hazardous or toxic substances will be in safe containers labelled with details of composition, properties and handling information. • The containers of hazardous substances should be placed in a leak-proof container to prevent spillage and leaching. • Maintain an inventory of hazardous materials when used in work sites. • Use proper protective equipment and procedures for managing spill, exposures, and other incidents. • Hazardous materials should be handled in accordance with the accepted practices. Only trained personnel should handle the materials with precautions by using required protection equipment.	Contractor(s)	Type of Hazardous materials produced Records of waste generated available weekly site inspection reports available

	Table 5-3 Generic ESMP of the HSDSP AF (V) – by Project Component				
	PROJECT ACTIVITIES / PROJECT COMPONENT	RISK/ IMPACTS	MITIGATION MEASURES	RESPONSIBILITY FOR IMPLEMENTATION	MONITORING INDICATORS
			• The wastes are transported by specially licensed carriers and disposed in a licensed facility. • Paints with toxic ingredients or solvents or lead-based paints will not be used		
		Occupational Safety and Health: The movement of trucks to and from the site, the operation of various equipment and machinery and the actual refurbishment activities will expose the workers to work-related accidents and injuries. Pollutants such as dust and noise could also have negative implications for the health of workers.	• The contractor(s) shall comply with all national and good practice regulations regarding workers' safety. • The contractor(s) shall have or receive minimum required training on occupational safety regulations and use of personal protective equipment. • The contractor(s) shall provide safety measures as appropriate during works such as installation of fences, fire extinguishers, first aid kits, restricted access zones, warning signs, overhead protection against falling debris, lighting system to protect hospital staff and patients against construction risks. • To manage potential COVID-19 infection risk as an OHS issue among construction workers, wash stations should be provided regularly throughout site, with a supply of clean water, liquid soap and paper towels (for hand drying), with a waste bin (for used paper towels) that is regularly emptied. Wash stations should be provided wherever there is a toilet, canteen/food and drinking water, or sleeping accommodation, at waste stations, at stores and at communal facilities. Where wash stations cannot be	• Health facility • Contractor(s)	• Use of Proper PPE is adhered to always. • Safety precautions and signs installed • COVID-19 prevention materials available.

	Table 5-3 Generic ESMP of the HSDSP AF (V) – by Project Component				
	PROJECT ACTIVITIES / PROJECT COMPONENT	RISK/ IMPACTS	MITIGATION MEASURES	RESPONSIBILITY FOR IMPLEMENTATION	MONITORING INDICATORS
			provided (for example at remote locations), alcohol-based hand rub should be provided. Relevant GIIP including WBG ESH Guidelines will be complied with. • Communication materials on COVID-19 prevention and control should be put in workplaces. • All work will be carried out in a safe and disciplined manner designed to minimize impacts on neighbouring residents and environment. • Workers' PPE will comply with international good practice (always hardhats, as needed masks and safety glasses, harnesses and safety boots) • Appropriate signposting of the sites will inform workers of key rules and regulations to follow.		
		Occupational and Community Health and Safety: Risks exist in relation to unforeseen circumstances.	• The contractor(s) shall prepare and implement an Emergency Response Plan to cope with risk and emergency (e.g., fire, earthquake, floods, COVID-19 outbreak). • The local construction and environment inspectorates and communities have been notified of upcoming activities • The public has been notified of the works through appropriate notification in the media and/or at publicly accessible sites (including the site of the works) • Contractors will take all measures to avoid disturbance and dangers to patients and staff in facilities receiving works and to	Contractors(s)	• Contractors have Emergency Response Plans to cope with risks and emergencies

Table 5-3 Generic ESMP of the HSDSP AF (V) – by Project Component					
	PROJECT ACTIVITIES / PROJECT COMPONENT	RISK/ IMPACTS	MITIGATION MEASURES	RESPONSIBILITY FOR IMPLEMENTATION	MONITORING INDICATORS
			neighbouring communities and businesses.		
		Temporary Visual Intrusion: Construction activities will require material, equipment and cordons at the health facilities or any other rehabilitation facilities. Since facilities under renovation would not be closed from access by the public, these activities and materials thereof will cause temporary visual intrusion at all sites. This may be exacerbated by the contractor setting up camp on site.	• The contractor(s) shall display signages around the work area to inform the bypasses of the civil work in progress. • Minimize visual intrusion by barricading work sites and by maintaining order in work sites.	Contractor(s)	• Appropriate safety measures in place at every site. • Appropriate signage always available.
		Archaeological Chance Finds This should concentrate on chance finds. Provision should be made to allow archaeologists to be present on site during any excavation periods if they so wish.	• The PIE Specialists should inspect all excavations regularly • where archaeological remains are found work must stop until the PIE has been given the all clear to proceed by the NMMZ • The PIE should contact the National Museums and Monuments of Zimbabwe (NMMZ) in the event of a significant archaeological find.	• PIE • Contractor • NMMZ	• Notifications being done whenever archaeological remains are found •
		Temporary disruption of Utilities Service: The demolitions and refurbishment activities may cause temporary disruptions of utility services such as electricity, communication, and water. Such disruptions may inconvenience the communities in the vicinity of the centres.	• The contractor(s) will use utility services, such as electricity and water as agreed with the Hospital Management. Where they are available, generators will be used, and temporary water tanks will be availed in case there is disruption of services. • No community utilities services will be used, however, if there is a need to use community utilities, communities will be consulted for approval, prior to use of the utilities.	Contractor(s)	• Contingent utility services always available for contractors.

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	PROJECT ACTIVITIES / PROJECT COMPONENT	RISK/ IMPACTS	MITIGATION MEASURES	RESPONSIBILITY FOR IMPLEMENTATION	MONITORING INDICATORS
		Noise: Noise and vibration caused by machines, site vehicles, pneumatic drills etc. will be commonplace during the refurbishment activities. These impacts can affect the quietness of the communities and can also impact patients and the healthcare workers.	• The contractor(s) is responsible for compliance with relevant national legislation with respect to ambient air quality, noise, and vibration. • The contractor(s) should not carry out construction activities generating high level of noise during healthcare activities, especially when services are being delivered to the clients. • When performing interior works during healthcare activities, the contractor(s) should communicate the work schedule with the relevant health facilities. • Construction noise will be limited to restricted times agreed to in the permit • During operations the engine covers of generators, air compressors and other powered mechanical equipment should be closed, and equipment placed as far away from residential areas as possible	Contractor(s)	• Noise generation protocol available for the contractors to follow. • Health facility sensitive Construction schedules formulated and implemented.
		Close working and poor working conditions may create conditions for the easy transmission of COVID-19 and the infection	• The contractor(s) shall follow Good International Industrial Practices (GIIP)	Contractor(s)	• Working conditions for workers • Use of appropriate PPE

	Table 5-3 Generic ESMP of the HSDSP AF (V) – by Project Component				
	PROJECT ACTIVITIES / PROJECT COMPONENT	RISK/ IMPACTS	MITIGATION MEASURES	RESPONSIBILITY FOR IMPLEMENTATION	MONITORING INDICATORS
		of large numbers of people, especially vulnerable groups.	and other guidelines such as the World Bank Group EHS Guidelines. • The contractor(s) shall also implement COVID-19 prevention measures. The contractor(s) shall provide workers with appropriate PPEs.		
		• There is a risk of Gender-Based Violence (GBV) or Sexual Abuse and Exploitation (SEA) at these refurbishment sites.	• The contractor shall ensure that workers are well briefed on the aspects relating to preventing GBV and SEA and no tolerance for these behaviours.	Contractor(s)	• Incidences of GBV/SEA
		• There is a risk of employing Workers who are under aged.	• Child labour or indentured labour is absolutely prohibited in the project. • Labour law prohibits anyone under 18 years to be involved in hazardous work.	• Health facility • Contractor(s)	• No underage employed
		Disruption of Utilities Service: The demolitions and refurbishment activities may cause temporary disruptions of utility services such as electricity, communication, and water. Such disruptions may inconvenience the communities in the vicinity of the centres.	• The contractor(s) will use utility services, such as electricity and water as agreed with the Hospital Management where the available generator at hospital will be used and temporary water tanks will be availed in case there is disruption of services.	Contractor(s)	• Incidences of utility disruptions
	Sub-Component 4.d: Case Management and Related Health System Strengthening.				
	Activities will strengthen the public health system's capacity to (i) provide medical care to COVID-19 patients through provision of medical supplies like oxygen concentrators and medical	**Infections**: There may be possible risk of COVID-19 virus infections at the treatment facilities to Health Care workers and general workers involved in activities such as transportation of COVID-19 affected	• Health facilities should establish and apply Standard Precautions including: ○ Hand Hygiene (HH). ○ Respiratory hygiene/cough etiquette. ○ Use of personal protective equipment (PPE).	Healthcare facilities, PIE	• Patients benefit from Isolation, care, and treatment of COVID-19 patients in healthcare facilities

	Table 5-3 Generic ESMP of the HSDSP AF (V) – by Project Component				
	PROJECT ACTIVITIES / PROJECT COMPONENT	RISK/ IMPACTS	MITIGATION MEASURES	RESPONSIBILITY FOR IMPLEMENTATION	MONITORING INDICATORS
	equipment like ICU sets (beds, ventilators) for selected treatment centres, (ii) improve referral of COVID-19 affected individuals to treatment centres through procurement of fully kitted ambulances; and (iii) provide food and basic supplies including linen and, depending on feasibility assessment and prioritization of needs, possibly menstrual hygiene kits for temporary isolation centres and treatment facilities.	individuals during operation, delivery and storage of goods and food.	○ handling of patient care equipment, and soiled linen. ○ Environmental cleaning. ○ Prevention of needle-stick/sharp injuries. ○ Appropriate Health Care Waste Management. • In addition, health facilities should establish and apply Transmission based precautions (contact, droplet, and airborne precautions) as well as specific procedures for managing patients in isolation room/unit. • Establishment of Standard precautions and Transmission based precautions should be in line with National guidelines for IPC in healthcare facilities and consider guidance from WHO and/or CDC on COVID-19 infection control: • WHO interim guidance on Infection prevention and control during health care when novel coronavirus (nCoV) infection is suspected; • WHO guidance on infection prevention and control at health care facilities (with a focus on settings with limited resources); • CDC Guidelines for isolation precautions: preventing transmissions of infectious agents in healthcare settings; and		• Better referral system available • Medical equipment and supplies available • Food and other non-food items available for patients,

	Table 5-3 Generic ESMP of the HSDSP AF (V) – by Project Component				
	PROJECT ACTIVITIES / PROJECT COMPONENT	RISK/ IMPACTS	MITIGATION MEASURES	RESPONSIBILITY FOR IMPLEMENTATION	MONITORING INDICATORS
			• CDC guidelines for environmental infection control in healthcare facilities.		
		• **Increased generation of infectious waste**: The Health facilities and laboratories will generate increased amount of waste, such as infectious sharps, infectious wastewater (including excreta (faeces and urine) and increased incinerator usage resulting in toxic emissions and ash. • These will need to be managed carefully to prevent public health risk and environmental impacts. Medical waste is contaminated with COVID-19 virus. Improper collection, transport, treatment, and disposal of infectious waste becomes a vector for the spread of the virus.	• All hospitals and laboratories should prepare waste management procedures in accordance with the project's **Infection Control and Waste Management Plan (ICWMP)** requirements that outline waste segregation on site, on site handling, collection, transport, treatment and disposal, and training of staff. • Each facility must draft an approved medical Waste Management Plan before beginning any medical waste-generating activities financed by the project in accordance with the ICWMP. The Medical Waste Management Plan to be approved by the PIE and World Bank • Wastes should be segregated at source in line with the ICWMP requirements. • The treatment of healthcare waste produced during the care of COVID-19 patients should be collected safely in designated containers and bags, treated and then safely disposed. • HCWM procedures should be in line with the Zimbabwe National guidelines for Infection Prevention and Control in healthcare facilities and take into account WHO guidelines for Safe management of wastes from health-care activities and WHO technical brief water, sanitation,	Healthcare facilities, PIU	• All Health facilities have a waste management plan/procedure. • Health care wastes collection, handling and treatment being done according to the project ICWMP requirements.

	Table 5-3 Generic ESMP of the HSDSP AF (V) – by Project Component				
	PROJECT ACTIVITIES / PROJECT COMPONENT	RISK/ IMPACTS	MITIGATION MEASURES	RESPONSIBILITY FOR IMPLEMENTATION	MONITORING INDICATORS
			hygiene and waste management for COVID-19; • Implement and ensure compliance with the Infection Control and Waste Management Plan (ICWMP) prepared for this project.		
		• Poor sanitation and improper management of wastewater related to COVID-19 diagnosis and treatment services transmit diseases to communities and pollute environment.	• Health facilities shall ensure the provision of safe water, sanitation, and hygienic conditions, which is essential to protecting human health during COVID-19 outbreak. • Enhanced cleaning arrangements should be put in place, to include regular and deep cleaning using disinfectant of food and drink facilities, toilets/showers, communal areas, including door handles, floors and all surfaces that are touched regularly. • ensure cleaning staff always have adequate PPE.	Healthcare facilities, PIU	• safe water, sanitation, and hygienic conditions available at health facilities, • No diagnostic waste water discharged to the environment. • All wastewaters channelled to treatment plants before being discharged into the environment
		• Hazardous materials used and generated during the provision of COVID-19 diagnosis, care, and treatment services • Hazardous chemicals in the hospitals and health care centres are limited to small volumes of laboratory reagents, chemicals, solvents, medicinal gases etc.	• The hospitals and laboratories should have hazardous material management procedures and procedures for reporting of incidents as outlined in the project ICWMP for further details especially on management and storage of reagents. • Hazardous materials should be handled in accordance with the accepted practices. Only trained personnel should handle the materials and precautions taken when handling materials by using required protection equipment such as ventilation hoods and personal protective equipment.	Healthcare facilities, PIE	• hazardous material management procedures and procedures developed.

	Table 5-3 Generic ESMP of the HSDSP AF (V) – by Project Component				
	PROJECT ACTIVITIES / PROJECT COMPONENT	RISK/ IMPACTS	MITIGATION MEASURES	RESPONSIBILITY FOR IMPLEMENTATION	MONITORING INDICATORS
		• **Vulnerable people excluded**: planning and design of measures to screen people for COVID-19 and information materials developed could exclude the most vulnerable, including the poor, elderly, indigenous peoples, people living with a disability and households headed by single women, who are also less likely to have access or be active on social media. • Vulnerable groups and people in the rural areas are at heightened risk if they contract COVID-19 due to their remoteness in accessing treatment (though their remoteness may protect them from contracting the virus). Their location may also make the diagnosing and treatment of the virus more difficult.	• Planning of containment measures and social restrictions need to consider the livelihood impact it will have for the population, in particular the most vulnerable (the poor, elderly, women single heads of household, IPs, those with disabilities). • Development of specific mitigation measures (Outside this Project) like social safety nets with cash transfers to specific population groups, ensuring that it does not exclude informal workers, the poor, home-based workers, etc. May also include food grants, essential basket of goods, childcare support for women, etc. • hazardous material management procedures and procedures Have clear Communication materials about (i) how to avoid contracting COVID-19 (good hygiene measures); (ii) symptoms of COVID-19; (iii) what to do if suspect have COVID-19. • Ensure that testing and treatment centres are disability inclusive. • Provide specific advice for people - usually women - who care for children, the elderly and other vulnerable groups in quarantine, and who may not be able to avoid close contact.	• MoHCC • GoZ • PIE	• Access to COVID-19 healthcare services Patients at Isolation Centers benefit from COVID – 19 Kits, menstrual hygiene kits, food and hygiene products
		• Focus on COVID-19 may redirect staff and resources at health facilities and negatively impact other areas, such as maternal health check-ups, vaccinations	• Hospitals and other health facilities must ensure they still have adequate staff to deal with ongoing medical needs.	Healthcare facilities, PIU	• People continue to have Access to other healthcare services

	Table 5-3 Generic ESMP of the HSDSP AF (V) – by Project Component				
	PROJECT ACTIVITIES / PROJECT COMPONENT	RISK/ IMPACTS	MITIGATION MEASURES	RESPONSIBILITY FOR IMPLEMENTATION	MONITORING INDICATORS
		for children and treatment of chronic diseases. • People, women with young children, pregnant women, the elderly, those with disabilities, chronic illness and other vulnerable populations, may be fearful of going to the hospital/health centre for fear of contracting the virus. • children missing out on needed vaccinations, women not seeking support during pregnancy, etc.	• Communication materials must stress that these normal services are still being provided, and explain measures taken in health centres to avoid COVID-19 risks This may include radio messages, Facebook, loudspeaker announcements, signage in hospitals, etc.		
	Sub-Component 4.e: Response Coordination and Monitoring & Evaluation.				
	It will finance operationalization of: • video-conference facilities in MOHCC Permanent Secretary Boardroom and sub-national EOC at Provincial Medical Directorates' offices. • rapid response teams including call centres through provision of Furniture and IT equipment to various sections of the MOHCC and vehicles for the monitoring programmes. • a COVID-19 response M&E action plan, • a stakeholder engagement plan and GRM,			Healthcare facilities, PIU, regional referral hospitals	

6. CLASSIFICATION, SCREENING, APPROVAL AND IMPLEMENTATION

6.1 INTRODUCTION

The Health Facilities will select sub-projects with the assistance of the District/Provincial Technical Teams. Figure 1-1 depicts the organisational chart indicating the responsibilities of the teams at different levels.

The HSDSP AF-(V) site-selection criteria will among other things include i) compliance to the Project Procurement Strategy for Development (PPSD) and ii) environmental and social approval after a screening process. WASH facilities and their waste streams will be sited so as not to pollute natural habitats or nearby communities or businesses, avoiding nuisance.

PPSD will be prepared by the PIE in collaboration with the MOHCC. The Project Procurement Strategy for Development (PPSD) will specify goods and services the envisaged project will finance through the RBF system. The PPSD will specify procurement approaches and methods, as well as provide the thresholds for selection methods as agreed with the Bank.

The main procurement packages envisaged in the first three months are essential laboratory supplies, vehicles for surveillance, case management and coordination; procurement of PPE, and delivery of medical consumables.

The sections below (6.2 – 6.5) detail the stages of the environmental and social screening process (the screening process) leading towards the review and environmental and social approval of any sub-project that will be undertaken in the HSDSP AF-(V). This will be used in conjunction with the HSDSP AF-(V) site-selection criteria.

6.2 SUBPROJECT PREPARATION AND APPROVAL

The following is an outline of the process that will be undertaken to oversee the subproject identification, preparation, screening, approval, and implementation process for all sub-projects. The different sub-projects may require additional Environmental Assessment (EA) work before final approval for implementation as discussed in table 6-1 below. The process will be guided by the Environmental Management Act, EIA regulations and World Bank safeguard policies and EHS Guidelines to address environmental and social management considerations under the project.

Table 6-1 Additional EA work for Sub-projects

NO.	SUB-PROJECT TYPE	ADDITIONAL EA WORK REQUIRED
1.	Refurbishment and Community Selected Sub-Projects	May require a site specific ESMP depending on the level of refurbishments or construction for isolation facility set up or other rehabilitation works, otherwise they will generally require screening and completion of an environmental and social checklist. (Appendix 11)
2.	RBF Implementation Sub-Projects	Will require screening and waste management activities in accordance with the ICWMP.
3.	COVID-19 Emergency Response	Will require screening and a subproject-specific action plan.

The HSDSP AF (V) has targeted poor communities with packages of Key RMNCAH-N and Other Related Health services, which are being financed through the Results-Based Financing (RBF), a strategic Services purchasing system. Through RBF, the project enables financing to flow directly to front-line service providers while increasing accountability for performance. Health Facilities in the targeted Districts will identify sub-projects and access funding through the RBF system based on results-verification reports, invoices, and payment data provided. The RBF program is anchored on payments for verified results — conditional on quality for the urban RBF, and on quality and utilization for the rural RBF.

6.3 EXCLUSION / ELIGIBILTY LIST

6.3.1 Exclusion List

Table 6-1 below provides criteria based on which subprojects and activities which will not be eligible for financing under HSDSP AF (V):

Table 6-2 Subproject and Activity Exclusion List

No.	NEGATIVE SUB PROJECT LIST
1	Require acquisition of land and physical or economic displacement of people.
2	Block the access to or use of land, water points and other livelihood resources used by others.
3	Encroach onto fragile ecosystems, marginal lands or important natural habitats (e.g., ecologically-sensitive ecosystems; protected areas; natural habitat areas, forests and forest reserves, wetlands, national parks or game reserve; any other environmentally sensitive areas)[16].
4	Impact on physical cultural resources of national or international importance and conservation value.[17]
5	Have risks assessed as requiring biosafety levels BSL-3 and BSL-4 containment[18].
6	Activities that may cause long term, permanent and/or irreversible (e.g., loss of natural habitat) adverse impacts such as dam construction.
7	Activities that have high probability of causing serious adverse effects to human health and/or the environment not related to treatment of COVID-19 cases.
8	Activities that may have adverse social impacts and may give rise to significant social conflict.

[16] Fragile ecosystems include such places as wetlands, which quickly degrade if not properly used. Marginal lands include lands that has little or no agricultural or industrial value, often has poor soil or other undesirable characteristics and often located at the edge of desolate **areas and can very easily be degraded if abused. So, these are ecologically sensitive areas which must be protected from any development that may adversely affect them.**

[17] A physical cultural resource (PCR) is a movable or immovable object or site of historical, architectural religious, or other cultural significance. Development should not impact on these important resources.

[18] **Biosafety level** (**BSL**), or **pathogen/protection level**, is a set of biocontainment precautions required to isolate dangerous biological agents in an enclosed laboratory facility. The levels of containment range from the lowest biosafety level 1 (BSL-1) to the highest at level 4 (BSL-4). At the lowest level of biosafety, precautions may consist of regular hand-washing and minimal protective equipment. At higher biosafety levels, precautions may include airflow systems, multiple containment rooms, sealed containers, positive pressure personnel suits, established protocols for all procedures, extensive personnel training, and high levels of security to control access to the facility.

9	Activities that may affect lands or rights of indigenous people or other vulnerable minorities.
10	Activities that may involve permanent resettlement or land acquisition, or adverse impacts on cultural heritage.

6.3.2 Eligibility List

Table 6-2 below provides criteria based on which subprojects and activities which will be eligible for financing under HSDSP AF (V):

Table 6-3 Subproject and Activity Eligibility List

No.	SUB PROJECT ELIGIBILITY LIST
1	Participating laboratories must possess working eyewash, safety showers, sink, autoclave, etc.
2	Sites where there are no negative significant impacts on natural habitats or cultural sites.

In addition to the above, any subprojects that would be categorised as World Bank Category A subprojects will not be eligible for financing under APPSA.

6.4 ENVIRONMENTAL AND SOCIAL SCREENING

This section outlines the stages of the environmental and social screening process (the screening process) leading towards the review and environmental approval of any sub-project that will be undertaken on the HSDSP AF (V). To facilitate environmental and social screening, the ESMF has provided a checklist for subproject screening that will assist stakeholders, proponents and project staff with the identification of environmental and social issues relating to the subproject location and the surrounding environment based on available knowledge and field investigations.

6.4.1 Environmental Screening

This initial screening will be carried out using the Environmental and Social Screening Form (Appendix 1). The Health Care Facilities will identify their sub-projects and will be responsible for the environmental and social screening of the sub-project (Figure 6-1). The HSDSP AF-(V) PIE Environmental Specialist will give overall guidance in the screening process approving or rejecting ultimately, whilst the District Environmental Health Officers will conduct the screening (i.e., filling out the form and doing the on-site evaluation) for both the health facility-based works and the selected community works that will be done through the facility.

The screening will be conducted to identify the possible site-specific impacts and safeguard issues associated with a particular activity. Each type of activity at a particular location should have its own screening form. The initial stage is a desk appraisal of the activities planned, including designs. The screening process will be carried out by the Provincial/District Technical teams as outlined above. This initial screening will be carried out using the Environmental and Social Screening Form (Appendix 1).

Completion of the screening form will facilitate the identification of potential environmental and social impacts, determination of their significance, assignment of the appropriate

environmental and social category, identification of appropriate environmental and social mitigation measures, determine if any further environmental and social work is necessary, if necessary. The Environmental and Social Screening Process is outlined in Figure 6-1 below. Once drafted, the HSDSP PIE Environmental Specialist will review the Screening Form before any more work is done just in case the activity is not eligible or does not contain the necessary information.

The extent of further environmental and social work required to mitigate adverse impacts for the sub-projects, will depend on the outcome of the screening process. Most of the sub-projects will adopt the ESMP in the ESMF and will only be required to do an environmental and social screening (Appendix 1) at the subproject selection/identification and complete an environmental and social checklist (Appendix 11) prior to commencement of subproject implementation. A few may require further EA work and the development of site specific ESMPs. The ESMP-checklists will specify potential adverse environmental and social impacts and mitigation measures. Within the ESMP checklists, the Environmental Monitoring Plans will be prepared for each subproject, where monitoring indicators, timing, methods, and institutional responsibilities will be specified. If there were to be a new HCF construction, an ESIA accommodating waste disposal facilities would be required, however this project is not going to finance any new HCF construction. Once all the requisite documentation has been compiled, the District Technical Team will make recommendations to the National Level for approval.

6.4.2 Assigning the Environmental Categories

The assignment of the appropriate environmental category will be based on the World Bank safeguard policy categorization and on the provisions of the EMA EIA Regulations. For HSDSP AF-(V), the environmental categorization remains “B” since the issues stem from minor works with a small footprint with limited and manageable adverse environmental impacts in addition to medical waste which can also be mitigated and managed with the application of appropriate mitigation measures. The project will continue to support strengthening of medical waste management and disposal systems in permanent and temporary healthcare facilities on an as needed basis since the main environmental issue associated with this project’s activities is health care waste management.[19]

The community activities will include community mobilization and health promotion by community health workers including HCC members of the following key interventions:

(i) WASH,
(ii) nutrition, breastfeeding, growth promotion and monitoring, and Vitamin A supplementation,
(iii) early pregnancy detection and referral,
(iv) reduction of adolescent pregnancies through communication for behavioural change, and
(v) early reporting and community psychosocial support for victims of SGBV including linkages/referrals to care. All interventions will incorporate gender mainstreaming through involvement of both females and males in the communities.

[19] Temporary health care facilities will need to factor in safe water, sanitation, and hygiene facilities (meeting quality standards; separation of infected vs. non-infected patients).

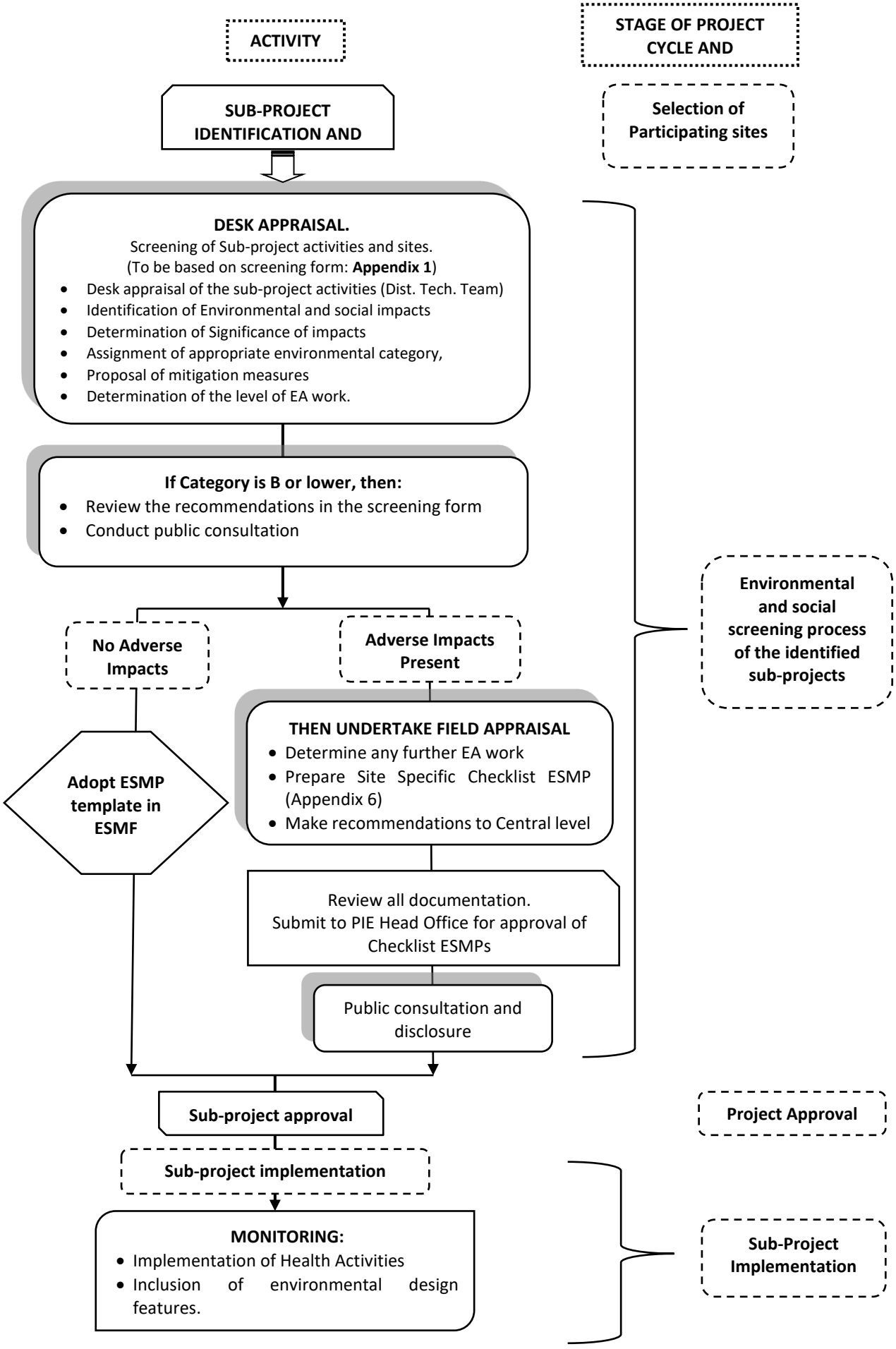

Figure 6-1 Flow for sub-projects identification, submission, evaluation and monitoring

New undertakings with environmental impacts under this AF include the COVID-19 response component. This component has activities such as support for basic handwashing and sanitation facilities (e.g., septic tanks or pit latrines; ventilated improved pit latrines, composting toilets, or pit latrines with slabs). It will finance, among others: (i) IPC self-care kits for quarantined cases, (ii) PPE and goods for health personnel involved in patient case management; (iii) medicines and medical supplies, diagnostic reagents including kits for public health facilities. The planned minor improvements in water and sanitation will not have any significant environmental impacts. Therefore, the issues remain the same as in AF IV, i.e., related to management of infectious healthcare waste and the occupational health and safety of workers coming into contact with the waste and illnesses including the new COVID-19.

Activities under Component 1, 2 and 4, which will support the strengthening of health Systems together with the COVID-19 emergence response, will result in the increase of health services utilization which will, in turn, lead to increases in the generation, handling and disposal of health care waste streams. Expected environmental risks would be related to the inappropriate and unsafe handling, transportation, treatment, and disposal of hazardous medical waste, including infectious waste; pharmaceutical waste; chemical waste; and sharps. Potential impacts are expected to be site-specific, reversible and can be managed through established and proven mitigation measures.

So, in categorisation the two systems, World Bank Categorisation and Zimbabwe categorisation will be considered:

(i) **The Zimbabwe legislation** classifies projects and activities into three types as follows:

Table 6-4 Zimbabwe Legislative Project Classification

TYPE	INTERPRETATION
Type 1:	Projects under this category **are listed in the Schedule** and are likely to have significant adverse environmental impacts whose scale, extent and significance cannot be determined without in-depth study. Appropriate mitigation measures can only be identified after such study. From the assessment of the project prospectus the projects are classified as requiring a full EIA.
Type 2:	Projects under this category **are listed in the Schedule** and are likely to cause environmental impacts, some of which may be significant unless mitigation actions are taken. Such projects cause impacts which are relatively well known and easy to predict. Also, the mitigation actions to prevent or reduce the impacts are well known. From the assessment of the project prospectus the projects are classified as not requiring a full EIA.
Type 3:	Projects under this category **are not listed in the Schedule** and are unlikely to cause any significant environmental impact and thus do not require any additional environmental assessment.

The World Bank requires that all projects financed by the Bank are screened for their potential environmental and social impacts to determine the appropriate extent and type of environmental work. The Bank classifies the proposed projects into one of four categories as follows:

Table 6-5 World Bank Project Risk Classification

CATEGORY	INTERPRETATION
Category A:	A proposed project is classified as Category A, if it is likely to have significant adverse environmental impacts that are sensitive, diverse, or unprecedented. These impacts may affect an area broader than the sites or facilities subject to physical works.
Category B:	A proposed project is classified as Category 'B', if its potential adverse environmental impacts on human populations or environmentally important areas – including wetlands, forests, grasslands, and other natural habitats – are less adverse than those of category 'A' projects. These impacts are site – specific, few if any of them are irreversible; and in most cases mitigatory measures can be designed more readily than for category 'A' projects.
Category C:	A proposed project is classified as Category C, if it is likely to have minimal or no adverse environmental impacts.
Category FI:	If it involves investment of Bank funds through a financial intermediary in sub-projects that result in adverse environmental impacts.

The Bank requires that all projects be screened, and the requisite environmental assessment work be carried out based on these screening results. To ensure that future small-scale sub-projects are implemented in an environmentally and socially sustainable manner the project has developed an environmental and social screening process for small scale sub-projects consistent with OP 4.01. The following table shows the possible categorisation of the project activities:

Table 6-6 Possible categorisation of the project activities

No.	ACTIVITIES	CATEGORY
1.	Minor civil works - Renovation/refurbishment/upgrading of facilities including isolation centers and other clinical facilities will involve various works inside the building, windows/doors replacement, roofing (if needed), facade works, installation of equipment like servers, and necessary improvement of existing infrastructure on the site.	B
2.	**The Community Level RBF activities will mainly be Promotive (WASH education information, etc) and preventive (Vitamin A, Monitoring, etc). The key interventions include:**	
	i. WASH education for behavior (**not facilities or equipment, however if the HCC identifies a need like a borehole or toilets, the identified need may be installed**),	B
	(i) nutrition, breastfeeding, growth promotion and monitoring, and Vitamin A supplementation	C
	(ii) early pregnancy detection and referral	C
	(iii) reduction of adolescent pregnancies through communication for behavioral change	C
	(iv) early reporting and community psychosocial support for victims of SGBV including linkages/referrals to care. All interventions will incorporate gender mainstreaming through involvement of both females and males in the communities.	C
3.	**COVID-19 Response. Activities will include:**	
	(i) procurement of medical supplies and equipment	C
	(ii) installation of water tanks in selected isolation centers and supplies for handwashing facilities	B
	(iii) basic sanitation facilities in critical areas	B
	(iv) medical waste management and disposal systems in permanent and temporary healthcare facilities as needed.	B

	(v)	equipping and strengthening functional skills laboratories for Emergency Obstetric and Neonatal Care and Family Planning in central, provincial and district hospitals (Sub-Component 2.a.)	B
	(vi)	improve laboratory capacity through procurement of Polymerase Chain Reaction (PCR) based laboratory test cartridges (Sub-Component 4.a.)	B
	(vii)	Supplying resources to clinical and laboratory facilities to enable response to COVID-19. It will finance basic laboratory equipment, test kits (Gene Xpert Cartridges for PCR test to diagnose COVID-19), PPE for surveillance and laboratory workers.	B

Zimbabwe EA procedures are generally consistent with the Bank's policies. However, there exists a gap regarding the screening of small-scale sub-projects where the sites and potential adverse localized impacts cannot be identified prior to the appraisal of the project. Therefore, the HSDSP AF-(V) will use the environmental and social screening process as described in this report.

6.4.3 Appraisal and Approval of Environmental and Social Work

The completed screening form along with any additional planning reports, will be forwarded to the review authority (Evaluations Committee), which is the Ministry of Health at National Level, represented by the HSDSP AF-(V) PIE ESS. The Sub-projects which do not require the preparation of an in-depth ESMP will automatically be approved based on the screening form and the project implementor, usually the contractor, is required to develop site-specific ESMPs for every activity based on its screening together with the requirements of this ESMF as its safeguards instruments. However, if the sub-project requires the development of an in-depth ESMP, then the review team (Evaluations Committee) will be assisted by Environmental experts from the EMA to make sure that all the requirements are in place and submitted to EMA for updating its records and making sure that the ESMP is aligned to the main ESMF. Such a sub-project may also require a no objection from the World Bank. All the documentation must be submitted to the HSDSP AF-(V) PIE ESS who will then submit to EMA head office when satisfied that all documentation is in place.

Generally, all the sub-projects that will be financed by HSDSP AF-(V) will not need any further EA work beyond just an ESMP checklist to guide the implementation of the ESMF. So, no further EMA approvals will be required, unless, for example, a major refurbishment of an entire hospital wing, is undertaken.

7. PROJECT COMPLAINTS, CONFLICTS AND GRIEVANCE REDRESS MECHANISM

7.1 INTRODUCTION

Implementation of sub-projects activities under HSDSP AF-(V) will take place in various locations in all the Target areas of the country. The implementation may generate several challenges and complaints especially those which relate to infringement of rights of sections of the society. As part of addressing such complaints and in the spirit of the continuous consultation process, a grievance redress mechanism has been developed for HSDSP AF-(V). The grievance redress mechanism (GRM) will consist of two parallel systems. These systems are: i) the Facility level GRM system for project implementation feedback including challenges and complaints and ii) the Word Bank Grievance Redress System (GRS) for non-compliance with environmental and social safeguards policies.

The GRM will be monitored by the PIE Communications Specialist with the support of MoHCC Health Promotion Department and Public Relation Unit.

The GRM will be a system by which queries or clarifications about the programme will be responded to, problems with implementation will be resolved, and complaints and grievances will be addressed efficiently and effectively. The purpose of the grievance redress mechanism is:

- To be responsive to the needs of beneficiaries and to address and resolve their grievances,
- To serve as a conduit for soliciting inquiries, inviting suggestions, and increasing community participation,
- To collect information that can be used to improve operational performance,
- To enhance the programme's legitimacy among stakeholders,
- To promote transparency and accountability,
- To deter fraud and corruption and mitigate programme risks.

7.2 FACILITY LEVEL GRM SYSTEM

The rationale for the facility level GRM, is because the CBOs and HCCs in the villages indicated that they were getting minimum assistance from the establishment and that they were dealing with community grievances through the police and the local elders.

The Grievance Redress Mechanism is further detailed in Appendix 9, and consists of the following components:

- The access point for impacted/concerned patients or people will be situated as close to the project affected person (PAP) as possible.
    - At the various Health Facilities phone numbers will be posted and notices written indicating the process to be taken when aggrieved,
    - At the various Health Facilities there will be a Suggestion Boxes (Also used as grievances boxes) situated in the reception area, where anonymous reports can be deposited. The community, the CBO and HCC will oversee the keys to the boxes,

- At all Ministry of Health and Child Care (MoHCC) Offices there will be Suggestion boxes situated in the reception area, where anonymous reports can be deposited,
- At the various Health Facilities and MoHCC Offices there will be a designated officer who receives, classify, and log all grievances,
- At all sub-project and CORDAID offices there will be a Suggestion box and a designated CORDAID staff will be responsible for receiving the Grievances, classifying, and logging them.
- All Suggestions boxes should be opened daily.

- The patient would normally be asked to submit a written down grievance to the Person in Charge of recording, who then refers the patient to see the sister in charge, who will try to resolve it, failing which the next steps will be taken. This is done so that a different person handles the case from the one who recorded it,
- The Administrator should give the complainant an acknowledgement of receipt containing an expectation of when they will receive a response,
- The Facility Manager assigns a member of staff to be responsible for the case, who ten assess and investigates the grievance to identify all the key facts,
- The responsible staff member in consultation with the Facility Manager. Then makes a resolution and the proposed actions are confirmed with CORDAID/MoHCC senior members of staff,
- A response is then communicated to the complainant within the timescale promised:
  - ✓ **For Priority 1 – urgent**, potential high health and high business impact. **This requires a response to the Complainant within three (3) working days,**
  - ✓ **Priority 2 - non-urgent**, lower health, environmental and social impact. This requires a response to the complainant within 2 working weeks,
- The complainant is given room to appeal to the MoHCC Head Office or the Courts of Law if they are not satisfied with the response. The appeal can be lodged with the Public relations Manager, MoHCC, Kaguvi Building, 4th Floor, Central Avenue, Harare.
- Once done the case is brought to a closure and all the staff members of the Facility are made aware of the complaint, any underlying issues and plans to prevent any future recurrence of the issue,
  - ✓ All complaints should be reviewed monthly as part of the quality assurance review meetings,
  - ✓ Any complaints where action can be taken to avoid recurrence must be acted upon and raised with the appropriate managers/teams across the Facility,
  - ✓ A monthly summary incident report is submitted to the Communications Specialist of CORDAID for record keeping and consolidation. He/she will ensure that all grievances are being recorded and resolved in a timely manner.

7.3 ADDITIONAL GRM APPROACHES

Besides the Project GRM, aggrieved persons can also employ additional channels to air their complaints. These include the World Bank Grievance Redress System (GRS) and the inspection Panel.

The objective of the World Bank's Complaints Procedure is to ensure that appropriate mechanisms are in place to allow individuals and communities to contact the World Bank

directly and file a complaint if they believe they are or might be adversely affected by the Project not complying with the World Bank's Environmental and Social Safeguards Policies.

Complaints must concern environmental, social and climate issues only and should not be accusations of fraudulent or corrupt activities in relation to project implementation – these are dealt with by the Offices of Audit and Oversight.

8. STAKEHOLDER ENGAGEMENT, COMMUNICATION AND DISCLOSURE

8.1 INTRODUCTION

Stakeholder engagements are critical in preparing an effective proposal and for the continuous implementation of the HSDSP AF-(V) programme. The engagement is done to ensure that potential environmental and social impacts are identified and adequately addressed.

The first step is to identify the key stakeholders and establish how/when they will be engaged including for the screening process and during any further environmental and social work. These consultations should identify key issues and determine how the concerns of all parties will be addressed. It is a requirement that appropriate mechanisms for ensuring full involvement and participation of the public is accorded priority. This should be a continuous process from screening, scoping, environmental and social impact analysis preparation, review and finalization.

The following is an outline of the stakeholder engagement process that the HSDSP AF-(V) will employ throughout its lifetime. However, all stakeholder consultations on the project are discussed in Appendix 5.

8.2 STAKEHOLDER ENGAGEMENT

8.2.1 Objectives of Consultations

i) Corporate Objectives:

- a coordinated approach to all engagement actions,
- consistency of messaging,
- management of stakeholder expectations
- reduction in the potential for delays in future project-related decision-making.

ii) Operational Objectives:

- acquisition of information from certain stakeholders to assist the Grievance Redress Mechanism (GRM),
- ensuring that stakeholders understand how they might be affected and their potential role in HSDSP AF-(V) design, implementation and impact management,
- provision of opportunities for stakeholders to express their opinions and concerns in relation to the GRM and HSDSP AF-(V),
- Ensuring that stakeholders understand the provisions of the project's safeguards instruments which include the ESMF and the ICWMP.

iii) The stakeholder engagement will be culturally appropriate to embrace all ethnic groups including the Indigenous Peoples (IPs)

8.2.2 Identifying Target Groups

Stakeholders for the purpose of this programme shall be defined as all those people and institutions that have an interest in the successful planning and execution of the activities. This includes those likely to be positively and negatively affected by the programme. Table 8-1 is a matrix that will be used to identify the key stakeholders for each sub-project:

Table 8-1 Stakeholder Identification Matrix

No.	AFFECTED PARTIES	HOW TO IDENTIFY THEM
1.	People living in the vicinity of the proposed works. (Staff, farmers, etc.)	• Identify the local government area(s) that falls within 500m radius of the proposed sub-project. • Review available data to determine the profile of the whole stakeholder or relevant group. • Use identified groups and individuals to tap into stakeholder networks to identify others.
2.	Special interest groups.	• Identify key individuals or groups through organized groups, local clubs, community halls and religious places. • Be aware of similar local groups, individuals or Government review teams.

The potential Stakeholders for HSDSP AF-(V) include the following:

Table 8-2 Potential Stakeholders for HSDSP AF-(V)

NO.	INSTITUTION	STAKEHOLDER
1.0	Stakeholder Communities	A provisional list of affected communities (villages) will be compiled based on the selected sites and area of impact

2.0	Government Ministries and Offices	• Ministry of Health and Child Care
		  ○ Central hospitals
		  ○ Provincial Hospitals.
		  ○ General hospitals. (These don't fall under District or Provincial Category)
		  ○ District Hospitals.
		  ○ COVID-19 Designated Hospitals.
		  ○ COVID-19 Isolation Centres.
		  ○ Clinics.
		• Ministry of Local Government and Public Works.
		  ○ District Administrators.
		  ○ Local Leadership (Chiefs), Headmen, Village Heads.
		• Environmental Management agency (EMA)
		• Social Welfare Depart.
		• Ministry of Water.
		• Ministry of Women Affairs

8.2.3 Stakeholder Engagement

A variety of engagement techniques will be used to build relationships with stakeholders, gather information from stakeholders, consult with stakeholders, and disseminate project information to stakeholders. This engagement process will provide a framework for achieving effective stakeholder involvement and promoting greater awareness and understanding of issues so that the project is carried out effectively, within budget and on-time.

The engagement process will be a continuous issue throughout the life of the project and will be used as a means of checks and balances for the proper implementation of the project. Thus, the process will employ a technically and culturally appropriate approach, which involves identifying the concerned/affected stakeholders, soliciting their views, and continuously checking if their views are being taken care of as the project implementation progresses

The engagement techniques used by the project Environmental Specialist will consider the cultural appropriateness and the purpose for engaging with the stakeholders. This will be crucial when dealing with some ethnic groups like the Indigenous Peoples (IPs) who may have special cultural requirements for engagement or even service delivery. Thus prior to any engagement event the following actions will occur:

- Preparation of standard information sheets tailored for specific stakeholder types,
- Selection of individual stakeholders with whom engagement will occur,
- Selection of methods for disclosure of information (including such topics as format, language, and timing),
- Selection of location and timing for engagement event(s) (avoiding busy work times, which may be seasonal, and days/times when special events may be occurring),
- Agreeing mechanisms for ensuring stakeholder attendance at engagement event(s) (if required),
- Identification and implementation of feedback mechanisms to be employed.

Where it is involving Indigenous People, the environmental Specialist will apply the procedures outlined in the IPPF (Appendix 4).

The stakeholder engagement process for the preparation of this ESMF was complicated by the ravaging COVID-19 pandemic which limited the study team's movements and consultations; thus, full scale site visits could not be conducted (Appendix 5). Engagement under normal circumstances and in pandemics is basically the same. The slight difference is that with COVID-19, gatherings are not encouraged.

8.2.3.1 Under normal conditions

The techniques that will be used for the continuous engagement process for this project include the i) potential project site visits, ii) One on one meetings with key stakeholders, iii) Focus group meetings with communities and Health Facility staff, and iv) Administration of Questionnaires to all key stakeholders. The appropriate application of these technics is further expounded in table 8-3 below:

Table 8-3 Stakeholder engagement techniques

No.	ENGAGEMENT TECHNIQUE	APPROPRIATE APPLICATION OF THE TECHNIQUE
1.	Correspondences (Phone, Emails)	• Disseminate information to Government officials, NGOs, Local Government, and organisations/agencies • Invite stakeholders to meetings and follow-up
2.	key informant interviews	• Seeking views and opinions • Enable stakeholder to speak freely about sensitive issues • Build personal relationships • Record meetings
3.	Advocacy meetings	• Present the Project information to a group of stakeholders • Allow group to comment – opinions and views • Build impersonal relation with high level stakeholders • Disseminate technical information • Record discussions
4.	Public meetings	• Present Project information to a large group of stakeholders, especially communities • Allow the group to provide their views and opinions • Build relationship with the communities, especially those impacted • Distribute non-technical information • Facilitate meetings with presentations, PowerPoint, posters etc. • Record discussions, comments, questions.
5.	Focus group discussions	• Present Project information to a group of stakeholders (8-15 people groups) • Allow stakeholders to provide their views on targeted baseline information • Build relationships with communities • Record responses
6.	Project website	• Present project information and progress updates • Present GRM and another relevant project documentation
7.	IEC Materials	• Brief project information to provide regular update • Site specific project information.
8.	Surveys	• Gathering opinions and views from individual stakeholders • Gather baseline data • Record data • Develop a baseline database for monitoring impacts
9.	Workshops	• Present project information to a group of stakeholders • Allow a group of stakeholders to provide their views and opinions • Use participatory exercises to facilitate group discussions, brainstorm issues, analyse information, and develop recommendations and strategies • Record responses

8.2.3.2 Under Pandemic Conditions

Under pandemic conditions appropriate engagement techniques should be adopted depending on the outbreak. The possible engagement techniques include the following,

- limited site visits,
- limited face to face interviews,
- limited physical completion of Questionnaires,
- limited focus group meetings,
- more of Virtual Meetings (Zoom, Microsoft Teams, Skype, etc),
- more of electronic administration of Questionnaires.

8.3 RISK COMMUNICATION AND COMMUNITY ENGAGEMENT (RCCE)

A clear and integrated Risk Communication and Community Engagement (RCCE) strategy and response is vital for community uptake of essential public health and biomedical interventions to prevent and control the spread of disease. This strategy ensures dialogue and participation of all stakeholders and affected communities during preparedness, readiness, and response and after action.

The risk communication must promote the uptake of public health services. People who are at risk and those who have been affected need to be part of the solution to their own problems. This can be achieved when the community actively participate from problem identification, preparedness, response/action, and after-action activities.

The COVID-19 outbreak and response has been affected by an overabundance of information from various sources — some accurate and some not — that makes it hard for people to decide which is a trustworthy source of information. However, MoHCC alone cannot address disease prevention and control. It must actively engage other stakeholders hence the need for a multisectoral approach.

8.4 DISCLOSURE

To meet the consultation and disclosure requirements of the Bank, once the Environmental Management Agency (EMA), the approval or licensing authority, has approved the ESMF, the Government of Zimbabwe (GoZ) will issue a disclosure letter to inform the Bank of (i) the Government's approval of the ESMF; (ii) the actual disclosure of these documents to all relevant stakeholders and potentially affected persons in Zimbabwe, and (iii) the Government's authorization to the Bank to disclose these documents on its website. Usually, disclosure of the safeguard documents must be completed prior to appraisal of the Project asper OP 17.50. However, since this is an emergency project, the disclosure of this ESMF was deferred to six weeks after project effectiveness. This ESMF, the ICWMP and other future safeguards instruments for the project will be disclosed both in-country and by the World Bank, in English. In country the safeguards instruments will be disclosed both on the MoHCC and Cordaid websites as well as the project website.

9. MONITORING AND SUPERVISION ARRANGEMENTS

9.1 INTRODUCTION

Safeguard implementation monitoring is critical to the success of the implementation of the project and its sub-projects to ensure adherence to the World Bank safeguards policies and the local EMA EIA Regulations

The lead implementing agent, the Ministry of Health and Child Care (MoHCC) with the help of the Project Implementing Entity (PIE), which is CORDAID, and the other implementing partners (relevant authorities) must monitor the environmental effects of project implementation and the success of mitigation measures. The implementing partners include:

- The Environmental Management Agency (EMA),
- Ministry of Public Service, Labour and Social Welfare (MOPSLSW),
- Ministry of Local Government and Public Works. (MLGPW),
- Ministry of Environment, Climate, Tourism and Hospitality Industry (MECTHI).

This monitoring is an important part of managing the impacts of the project. This section presents the monitoring plan for the HSDSP AF-(V). Contractors will be required to formulate the site-specific ESMP checklist for project activities under the guidance of the PIE Environmental Specialist. From time-to-time, the PIE Environmental Specialist or his or her designees will visit sites to determine compliance with the ESMP checklist. Appendices 6 and 7 contain ESMP monitoring templates which both contractors and the PIE can use to monitor project compliance with environmental and social safeguards.

Supervision and monitoring are key components of the ESMF during project implementation and must be undertaken during the HSDSP AF-(V) implementation phase to authenticate the effectiveness of impact management, including the extent to which mitigation measures are being successfully implemented. The aim of monitoring will be to:

- Improve environmental and social management practices,
- Check the efficiency and quality of the EA processes,
- Establish the scientific reliability and credibility of the EA for the project and
- Provide the opportunity to report the results on safeguards and impacts and proposed implementation of mitigation measures.

The three main components of the Supervision and monitoring are:

- Compliance monitoring,
- Impact monitoring and
- Cumulative impact monitoring.

9.2 COMPLIANCE MONITORING

This is to authenticate that the required mitigation measures, which are the environmental and social commitments agreed on by the implementing agency, local implementing agencies and contractors are being adhered to. A monitoring framework will be developed based on agreed prototype sub-projects as they are specified in the positive list of projects. The PIE will be responsible for undertaking compliance monitoring.

9.3 IMPACT MONITORING

The PIE will monitor sub-projects impacts mitigation measures. The Environmental and Social Safeguards agreed in the contract specifications should be monitored to ensure that works are proceeding in accordance with the laid down mitigation measures. The PIE and implementing entities should ensure that the project implementers submit reports on work progress and any challenges in observing the Environmental and Social Safeguards. The monitoring results should form a major part of the compliance reports to be submitted by the PIE to EMA.

9.4 CUMULATIVE IMPACTS MONITORING

The impacts of the HSDSP AF-(V) on the environmental and social resources within the project areas should be monitored with consideration to other developments which might be established or are already existing. Project screening should identify such other current or planned development which could impact the environmental or social performance of project activities or resources. The PIE will reach out to and collaborate with proponents of other development projects as necessary and possible to compare Environmental and Social Safeguards guiding the individual projects implementation to ensure coordinated and comprehensive management of cumulative impacts.

Th PIE should monitor the cumulative impacts from ward and community level (project site) to the larger scale for all sub-projects at District, Provincial and National level.

9.5 AREAS TO BE MONITORED

It is recommended that all environmental parameters mentioned above be monitored during the implementation and operation stages and any impacts should be mitigated as soon as possible. The beneficiaries and the PIE should monitor daily.

It is recommended that all environmental parameters mentioned below be monitored during the implementation and operation stages and any impacts should be mitigated as soon as possible. The Health Care Facility management, MoHCC and the PIE should monitor daily. Contractors (Supervising Engineer, site foreperson or other relevant on-site supervisor) are expected to note any environmental or socially related issues or accidents daily during works.

While monitoring, when any significant impacts are detected, the monitoring team should meet and address the issue. All team members should keep records of such meetings.

9.5.1 Health Care Waste

Project activities will generate medical waste which will include hazardous materials such as infectious waste, radiological waste and laboratory reagents. Therefore, participating facilities will be monitored to ensure that they are managing the wastes according to agreed-upon protocols. Table 5-3 – Sub-component 1a, 1c, 1d. and the project ICWMP contains more details.

9.5.2 Renovation/Upgrading/Refurbishment Waste

Solid and liquid waste will be generated from these activities; therefore, the disposal practices of the participating healthcare facilities will be monitored to ensure avoiding pollution of the environment. The management of asbestos waste is of particular importance due to its hazardous nature and so its disposal will be monitored. Through consultations and other means, communities must be discouraged from reusing asbestos containing materials.

Waste or other materials could lead to pollution of the water and the soil. Therefore, should the need arise, the project will monitor the amount of pollutants in the soil or water. Table 5-3 – Sub-component 4c further elaborates on the mitigation measures.

9.5.3 Ambient Air Quality

All air polluting activities need to be checked regularly to minimise their effect on air quality. Some examples are the emissions from incinerators being used to process infectious healthcare waste. See the ICWMP for more information on emissions levels. The emissions levels of incinerators must be measured to ensure compliance with requirements. Dust levels from renovation/upgrading and other related activities should also be monitored and controlled. Table 5-3 – Sub-component 4c further elaborates on the mitigation measures.

9.5.4 Occupational Health and Safety

The work force should be monitored in order identify any threats. Contractors are to record and report accidents, fatalities, illnesses and incidents daily. The health and safety of other workers participating in project-financed activities will similarly be monitored for accidents and any project related illnesses. Table 5-3 – Sub-component 4c further elaborates on the mitigation measures.

9.5.5 Relevant Licences, Permits, monitoring for Groundwater

Before a borehole is drilled, authorization to drill the borehole (Borehole Drilling Authorisation) must be sought first from the appropriate Catchment Council (section 34 of the Water Act (CAP 20:24) and SI 206/2001). It is illegal to drill a borehole without the authorization and after drilling, all boreholes must be registered with the Zimbabwe National Water Authority (ZINWA) or the nearest Catchment Council Offices.

To be able to utilise the water from the drilled Borehole, a Groundwater Abstraction Permit is required (section 34 (1) and (2) of the Water Act (CAP 20:24) and SI 206/2001). It is illegal to abstract water without a valid permit obtainable from the appropriate Catchment Council.

Once the borehole has been drilled for potable water purposes, the quality of the water must be ascertained in line with Section 9 (1) of the Food and Food Standards (Inspection and Certification) Regulations, 2015, together with requirements of the Zimbabwe Food and Food Standards (Mineral and Bottled Water) Regulations 2002 (FFS) (Which are equivalent to the WHO Guidelines for Drinking Water Quality).

The quality of the drinking water being supplied by the participating institutions that have been assisted with the installation of water tanks must be monitored quarterly for borehole sources and monthly for surface water sources.

9.6 THE MONITORING PLAN

The monitoring plan summarizes the main issues of concern in Table 9-1 below. It provides specific details including parameters, frequency and responsible entities. Appendix 7 presents a template monitoring form which can be used for each activity or healthcare facility.

Table 9-1 Draft Monitoring Activities and their Indicators

ISSUE	METHOD OF MONITORING	AREAS OF CONCERN	POSITIVE INDICATOR	FREQUENCY	RESPONSIBLE AUTHORITIES
Noise	Noise monitoring should be carried out on an ad-hoc basis by the Environmental Monitor or the PIE to establish noise levels in the work areas and adherence to working times	• Noise Levels. • Adherence to restricted working times. • Use of low noise equipment. • Noise suppression •	Noise levels at the nearest sensitive receiver would be kept to a minimum so as not to disturb the peace of the patients or other neighbours if applicable. EHS General Guidelines on noise level for construction applies.	Regularly and ongoing as project is implemented.	• PIE • MoHCC • Contractor controls noise levels
Health	PIE must ensure that education and awareness campaigns are implemented. The Ministry of Health should carry out awareness campaigns on Hospital Acquired diseases. PIE must mainstream HIV/AIDS and COVID-19 issues into the project implementation programme. Site visit observation for worker OHS and contractor reporting on accidents, incidents, and fatalities.	• Public health • Waste management at Sub-project sites. • Disease outbreak due to concentration of people at the Sub-project sites. • Disease outbreak due to dust and water pollution. • Worker OHS: Project related accidents, incidents, or fatalities • Health and Nutrition status • Use of proper PPE and other necessary supplies such as sanitizer • special COVID-19 occupational health and safety guidelines and practices • case detection • psychosocial support. • Level of WASH issue. • Quality of Facility sanitation (WASH).	• Reduction in number of cases of such diseases as, HIV/STD related diseases recorded at hospital and medical clinic • Worker OHS: 1. Low or decreasing accidents, incidents, and fatalities. 2. Observed proper PPE, use of safety supplies and equipment. • Percentage of facilities with adequate and functional sanitation facilities for both staff and patients at agreed standards.	Regularly and ongoing as project is implemented • Project related accidents, incidents or fatalities are to be reported to the PIE as soon as they occur, or project officials find out. PIE will report to the WB as soon as it finds out. Follow-up investigations will be conducted, as necessary. • WASH facilities are inspected on a **quarterly** basis, together with the whole health Care facility by the Environmental Health Depart of MoHCC.	• PIE • MoHCC • RDCs • Local Leadership • Contractor

ISSUE	METHOD OF MONITORING	AREAS OF CONCERN	POSITIVE INDICATOR	FREQUENCY	RESPONSIBLE AUTHORITIES
Waste Management	For renovation/upgrading/refurbishment: Observations should be made on how the contractor is handling general waste, hazardous waste including asbestos containing materials (ACM) and liquid waste. For medical waste, which is hazardous, facilities will develop waste management plans which will be monitored for compliance. Consult the ICWMP for further details.	• Hazardous waste identification. • Waste segregation on site. • Waste handling facilities. • Waste temporary storage areas. • Waste transportation methods. • Functioning incinerator • Use of proper PPE • Home based Health Care waste. •	• Hazardous waste properly delineated and stored • Proper transportation of hazardous waste available • designated waste management site being used for hazardous waste disposal. • Hazardous Waste properly classified. (**Hazardous waste** is divided into four **categories** denoting environmentally safe (blue), low **hazard** (green), medium **hazard** (yellow) and high environmental **hazard** (red))	Regular, weekly monitoring of hazardous construction waste and hazardous medical waste.	• PIE • MoHCC • Contractor • For health care waste, the health care facilities
Air Pollution	Observations should be made on the level of dust generated during the renovation and rehabilitation activities by the Environmental Monitor or PIE. Dampening should be carried out if levels are unacceptable and there should be no open burning of construction waste.	• Levels of dust emissions • Controlled areas for debris • Dust suppression measures • Proper PPE provided	• Deposition of dust on surfaces should decrease with increased dampening. • Appropriate PPE for protection from dust always provided. (See IWCMP for details)	Weekly monitoring of dust suppression measures.	• EMA • MoHCC • PIE • RDCs
Water resources	• Water resources should be managed well • Project implementer should test borehole water quality in the area to ascertain the suitability for human consumption if a borehole will be financed. • Project activities should not pollute or unduly disturb water resources. All waste should be managed properly and not lead to pollution of water resources.	• Watercourses and impoundments. • Surface water quality • Ground water quality • Recommended distances from watercourses.	• water resources should be managed to carter for environmental concerns. • Pollution of water resources monitored/detected early, and remedial measures taken on time	• Tests for water quality from installed potable water facilities to be done regularly (at least once per year) • Boreholes should be tested at least once a year if there is no problem, but once pollution is suspected a more frequent regime is adopted depending on the incident. • For surface waters the testing regimes depend on the size of the	• MoHCC • PIE • Subproject implementors •

ISSUE	METHOD OF MONITORING	AREAS OF CONCERN	POSITIVE INDICATOR	FREQUENCY	RESPONSIBLE AUTHORITIES
				treatment plant, ranging from hourly for large plants to daily for smaller plants.	
Complaints	The PIE should inspect the record of complaints made by residents, to be kept by the beneficiaries, and should check that action is taken quickly and that the number of complaints does not rise significantly. The GRM should be employed.	• Complaints • Remuneration of HCWs • Work safety measures • accidents caused by project activities and reported • Safety equipment (PPE) available • Information, communication, capacity building • Working conditions for workers • Incidences of GBV/SEA • No underage employed • Incidences of utility disruptions	Number of Cases resolved within stipulated time frame of 3 working days for priority 1 and 3 working weeks for priority 2.	Monthly monitoring of the complaints registers.	• PIE • MoHCC • RDCs • EIA Department

9.7 ANNUAL MONITORING, REPORTING AND REVIEWS

Environmental monitoring needs to be carried out during the implementation of the Sub-projects. Monitoring of the compliance of sub-project implementation with the mitigation measures set out in the sub-project's ESMP, will be carried out by the PIE, where relevant, jointly with the support from community leaders and local authorities and, extension teams. MoHCC Local Offices should supervise the monitoring activities and are required to report annually on sub-project activities during the preceding year. The PIE will submit biannual monitoring reports on safeguards matters and ESMF implementation to the WB. Table 9-2 below details the reporting arrangements for the environmental and social safeguards implementation:

Table 9-2 Reporting arrangements

No.	Issue/report	Reporting entity	Recipient of report	Frequency of reporting
1	Biannual progress reports on safeguards status. and the implementation of instruments (i.e., the ESMF, ESMPS, Checklists, etc.	• PIE Env. Specialist • PIE Communications Specialist	• World bank • MoHCC	Biannual
2	Project related accidents, incidents and fatalities	• PIE project personnel • PIE Team Leader • Sub-project leaders	• World bank • MoHCC • PIE	As soon as project personnel become aware of them
3	Consultation of Indigenous Peoples, project progress and any unexpected and unintended events affecting Indigenous Peoples	• Sub-project applicants • PIE Env. Specialist • PIE Communications Specialist	• affected indigenous communities • HSDSP AF-(V) PIE • World bank • MoHCC	As and when an incident has occurred.
4	SGBV reporting and community psychosocial support	RBF activity by community health workers. (CHW).	• HSDSP AF-(V) PIE • World bank • MoHCC	Monthly and as soon as when an incident has occurred.

Compliance monitoring comprises on-site inspection of activities to verify that measures identified in the ESMP, are being implemented. This type of monitoring is like the normal tasks of a supervising engineer whose task is to ensure that the Contractor is achieving the required standards and quality of work. An annual inspection report must be submitted (together with the annual monitoring report) to WB for review and approval.

Annual reviews may be carried out by an independent local consultant, NGO or other service provider that is not otherwise involved with HSDSP AF-(V). Annual reviews should evaluate the annual monitoring report from MoHCC Local Offices and the annual inspection report from PIE. The purpose of the reviews is two-fold:

- To assess compliance with the ESMF requirements, learn lessons, and improve future ESMF performance,
- To assess the occurrence of, and potential for, cumulative impacts due to project-funded and other development activities.

The annual reviews will be a principal source of information to the PIE for improving performance, and to Bank supervision missions. Thus, they should be undertaken after the annual report on monitoring has been prepared and before Bank supervision of the project.

9.8 MONITORING BUDGET AND TIMELINE

The budget and timeline for the Supervision and monitoring of the implementation of the ESMF has been included in the main budget in section 10.4 of Chapter 10.

9.9 MONITORING INDICATORS

The purpose of monitoring indicators is to measure the extent to which the interventions in the management of environment and social impacts have achieved expected result and decide if further interventions are needed.

To be able to assess the effectiveness of the proposed rehabilitations, installations, health care supplies and the subsequent implementation, operation and maintenance, the following will be used as indicators for monitoring the rehabilitation programmes:

Table 9-3 Monitoring Indicators

No.	ANTICIPATED IMPACTS OF HSDSP AF-(V) SUB-PROJECTS	POSSIBLE MONITORING INDICATORS
1.0	Construction Waste management	• Number of specific areas for waste disposal in appropriate formal dumping sites. • Volumes of Toxic waste Segregated. (Hazardous chemicals, infected samples, obsolete chemicals, Asbestos Containing Materials (ACM)) • Number of human resources employed in waste management • Number of Obstructions of roads and walkways.
2.0	Hazardous and medical waste	• Conditions of the Waste handling System (Segregation at source, handling, managing, transporting, Treatment and disposing) • Volumes of Infectious waste generated from Facilities, e.g., isolation centres
3.0	Land degradation/Soil erosion	• Surface areas rehabilitate with terraces, erosion ditches, etc. developed. • length of storm water channels rehabilitated. • Areas of Patches revegetated or regressed
4.0	State of vegetation	• Area with planted trees and shrubs/grasses • Areas of Patches revegetated or regressed
5.0	Drinking Water Quality.	• Water sources for participating institutions complying with the national Drinking Water Quality Standards (pH, temperature, visual observations (presence of litter).
6.0	Ambient Air pollution	• Level of air Quality vs national and WB standard. • Availability of Correct PPE.
7.0	Noise generation	• Level of noise within an allowable limit o Close to Patient Wards the noise levels should not be more than 30 dB LEq. • Noise making period complying with the work time (7am-6pm).

No.	ANTICIPATED IMPACTS OF HSDSP AF-(V) SUB-PROJECTS	POSSIBLE MONITORING INDICATORS
8.0	Occupational health and safety (OHS), and Community Transmission and Exposure	• Incidences of work-related injuries and fatalities at sites. • Number of non-health care staff at project sites with health problems. • Number of Health Care workers infected during operations (Incidences of infection at work). • COVID-19 cases emanating from or related project sites or Health Facilities. • Number of accidents, incidents, and fatalities caused by project activities and reported. • Number of workers accessing HIV/AIDS services needed. • Number of non-compliance events to labour/employment act and other applicable obligations (compliance to the Health Care Workers code of conduct, labour contracts, and labour rights). • Number of complaints regarding the project. • Number of Safety equipment (PPE) available at construction site for workers. • Number of speed control ramps with appropriate road signs in case of roads.
9.0	Gender main streaming	• Proportion of women among contract or employees ' • Number of reported sexual abuse case involving sub-project workers. • Ratio of men to women trained (ensure equity in the training processes).
10.0	Risks to vulnerable Groups	• Number of vulnerable persons served, (Easy of access of services). (vulnerable persons include people with chronic conditions/disabled, poor people, migrants, the elderly and, disadvantaged sub-groups of women, Indigenous Peoples (IPs).) • Number of Special cases like Ips.
11.0	Handling of Project and Personal Information	• Number of complaints of leakage of patient personal information. • Number of safeguards training courses conducted for staff and beneficiaries. •
12.0	Training /induction and capacity building	• Dates. • number of trainings. • and topics covered.
13.0	Handling of Grievances	• Percentage of grievances addressed within 4 weeks of initial complaint being recorded.

10. INSTITUTIONAL CAPACITY FOR THE ESMF IMPLEMENTATION

10.1 PROJECT IMPLEMENTORS

In order to assure the successful implementation and monitoring of the environmental and social management framework (ESMF), the target groups and stakeholders who will play a role in the implementation of the ESMF must be provided with appropriate training and awareness. This is because the implementation of the activities will require inputs, expertise and resources which will be adequately conducted if the concerned parties are well-trained. These people include the following:

(a) National level

i) Project Implementation Unit (PIE)

The Project Implementation Unit (PIE) is primarily responsible for implementing the project and reporting on the use of World Bank-GFF funds. CORDAID will remain as the PIE and will receive World Bank-GFF funds through a Designated Account. The roles and functions of CORDAID are elaborated in section 1.7.

The PIE has strengthened its capacity to implement the project's environmental and social safeguards and this ESMF, by engaging a Communications Specialist for social issues and an Environmental Specialist for environmental issues.

The MOHCC PCU will continue to be the national purchaser for RBF services its roles are also elaborated in section 1.7.

The other government entities that will support the PIE in its activities include:

- MoHCC - Environmental Health Department,
- MoEWC - EMA District Officers and ZINWA,
- MOPSLSW - Social Welfare Department,
- MLGPW - Public Works Department,

ii) PIE Environment Specialist

The PIE Environmental Specialist will ensure the provisions of this ESMF are implemented, all Environmental and Social Safeguards are adhered to and that the site-specific ESMPs are formulated, implemented and adhered to. He/she will need to have a Masters' degree or advanced degree in Environmental health, Environmental Sciences, Public Health, Nursing, Infection Prevention and control, Natural Resource Management, Development Studies, Social Sciences, or any other relevant field.

His or her main functions are (i) capacity building, (ii) Analytical and Technical support and (iii) Operations, Management, and Implementation of the ESMF. In capacity building, conduct or ensure continuous training on the project's safeguards instruments to all CORDAID staff, MoHCC staff (National, Provincial and District), etc. The training will be in the form of initial awareness and refresher workshops on specific safeguards issues together with on-the-job practical demonstrations of the development and implementation of the site-specific ESMPs. Another important function of the PIE Environmental Specialist will be to ensure quality control and clearance of site-specific ESMPs and any other environmental documentation.

In terms of analytical and technical support he/she will assist the PIE in ensuring that the project together with-it sub-projects is environmentally and socially compliant with the ESMF requirements. He/she will provide technical support and guidance during sub-project development, proposals and Environmental and Social screening activities and assist in the inclusion of environmental and social issues in the Sub-Projects selection process.

Operations, Management, and Implementation of the ESMF he/she will advise on administrative measures and actions required for ensuring the compliance with requirements set regarding environmental and social safeguard measures and undertake periodic monitoring and evaluation of project activities against standards of the safeguard guideline.

iii) PIE Communications Specialist

The PIE Communications Specialist will serve the purpose of making sure the social provisions of this ESMF are implemented, all Social Safeguards are adhered to and that the capacity of the beneficiaries to implement the site specific ESMPs is enhanced. He/she will also be responsible for the implementation of the project's GRM.

His/her main functions are (i) capacity building, (ii) Analytical and Technical support and (iii) Operations, Management, and Implementation of the GRM. In capacity building Conduct continuous training on the project's social safeguards instruments and the project's GRM, to all CORDAID staff, MoHCC staff (National, Provincial and District) etc. The training will be in the form of initial awareness and refresher workshops on specific safeguards issues together with on-the-job practical demonstrations of the implementation of the project's GRM.

In terms of analytical and technical support he/she will assist the PIE in ensuring that the project together with-it sub-projects is socially compliant to the project with the ESMF requirements. He/she will provide technical support and guidance during sub-project development, proposals and social screening activities and assist in the inclusion of social issues in the Sub-Projects selection process.

Operations, Management, and Implementation of the ESMF he/she will advise on administrative measures and actions required for ensuring the compliance with requirements set regarding social safeguard measures and undertake periodic monitoring and evaluation of project activities against standards of the safeguard guideline.

For the smooth implementation of the Zimbabwe HSDSP AF-(V) ESMF, staff at national level must understand the environmental and social issues pertinent to their involvement. The groups that may need training at national level will include:

- PIE staff,
- MoHCC staff,
- Other collaborating institutions.

Other institutions such as MoHCC - health promotion department, MoHCC - Environmental Health Department, MoEWC - EMA District Officers, MOPSLSW - Social Welfare Department, and MLGPW - Public Works Department have regulatory roles to ensure that national environmental and other standards are met through monitoring, site visits, permit obligations and other means.

(b) Provincial, District and Local level (Technical Teams)

The PIE Environmental Specialist together with the Communications Specialist, will be assisted in their duties by the Provincial and District Technical Teams (See Section 6.1), who will be led by MoHCC - Environmental Health Department, Health Promotion department and Public Relation Unit and consist of representatives of the following institutions at each level:

- MoHCC - Public Relation Unit,
- MoHCC - Health Promotion Department,
- MoHCC - Environmental Health Department,
- MoEWC - EMA District Officers,
- MOPSLSW - Social Welfare Department,
- MLGPW - Public Works Department,
- MoEWC – ZINWA,
- CORDAID.

The technical teams will be responsible for completing the environmental and social screening form (Appendix 1) to be able to identify and later mitigate the potential environmental and social impacts of HSDSP AF-(V) subprojects.

At Facility Level the groups that will receive environmental and social training to enable them to implement the ESMF of the project will include the following:

- CHW,
- Head Nurse,
- Nurse in Charge.

Further details on institutions involved in project implementation can be found in section 1.7 “Institutional Arrangements”.

10.2 CAPACITY BUILDING REQUIREMENTS

The proposed Zimbabwe HSDSP AF-(V) activities will be numerous and challenging. Successful implementation of the project activities will require dynamic and multi-disciplinary professionals. Therefore, regular short and tailor-made training courses and seminars will be required to reinforce the capacity and skills of project implementers at all levels during the entire project period.

The stakeholders have different training needs ranging from awareness, sensitization, and comprehensive training,

- Awareness raising will cause the participants to acknowledge the significance or relevance of the issues, but without in-depth knowledge of the issues,
- Sensitization will cause the participants to be familiar with the issues to the extent of demanding precise requirements for further technical assistance,

- Comprehensive training will raise the participants to a level of being able to train others and to competently act on project environmental and social matters in their areas.

Training and seminars will be undertaken and table 10-1 below provides costs estimates for the identified capacity building activities. The basis of the estimates is on some of the following:

- Prevailing costs of goods and services offered in typical urban or rural areas,
- An average number of 20 people for a District/local level team,
- The length of training sessions will depend on the course and will vary from 3 days to about 2 weeks,
- The estimated costs include training costs/fees, hire of rooms, food for participants, per diems, and transport costs. Training subsistence allowances have been estimated at US $10.00 per participant per day while a lump sum of US $6 000.00 has been included for each training session to cover the costs of the trainer,
- The HSDSP AF-(V) will be working in:
    - Eighteen (18) Rural Districts (424 health facilities) in terms of its RBF activities,
    - Two (2) urban districts, (34 health facilities) in terms of its RBF activities,
    - Five (5) isolation/treatment facilities for COVID-19 Response (for installation of water tank and some minor works, PPE, Ventilators),
    - One hundred and four (104) hospitals only for provision of PPE),
    - Ten (10) laboratories for Gene Xpert Cartridges for PCR test to diagnose COVID-19.

Table 10-1 Summary of Capacity Building Requirements and Cost Estimates

No.	TRAINING ACTIVITY	TARGET GROUP / TRAINER	MEANS OF VERIFICATION	COST ESTIMATES
1.	• Environmental and Social Safeguards – ESMPs of the sub-projects: - Screening process. - Use of checklists - Preparation of terms of reference. - Identification of Impacts - EIA report preparation and processing - Strategic action planning for Environmental Management - Policies and laws in Zimbabwe World Bank Environmental and Social safeguards Policies.	• District Health Office Teams • District EMA Units • District health Workers • Extension workers in project impact areas. • Relevant Line Ministries • Community Members **<u>TRAINER: Dept of Environment or private consultant</u>**	In each District: • 10 members of District Health Office Team are trained. • 5 members of each relevant line ministry trained. • 5 Community members	@ US $ 800.00 per District for two session each, during the entire project period) **Venue: Facility Boardroom** **Length:** 5 days **Cost**: US $45 000.00
2.	Environmental Social Management Framework (ESMF)and Infection Control and Healthcare Waste Management Plan (ICWMP)	• All healthcare workers (HCW) • All workers involved in the Implementation of this project	In each District: • 10 members of District Health Office Team are trained. 5 members of each relevant line ministry trained.	
3.	Medical Waste Management Training: • Use of the three-bin system (colour coded bins) • How to operate an incinerator • Importance of Personnel Protective Equipment (PPE) • Waste weighing and record keeping	• All HCW and all involved in the implementation of the project • Incinerator operators • All waste handlers	In each District: • 10 members of District Health Office Team are trained. • 5 members of each relevant line ministry trained. • 5 Community members	
4.	Construction site waste management appropriate for minor works such as renovation, upgrading, etc.	• PIE Env Specialist • Contractors • All waste handlers	In each District: • 10 members of District Health Office Team are trained. • 5 members of each relevant line ministry trained. • 5 Community members	
5.	• Water, Hygiene and Sanitation issues • Water - Water rights	• Extension workers in project impact areas • Community members	In each Province: • 10 members of Provincial/District Health Office Team are trained.	

No.	TRAINING ACTIVITY	TARGET GROUP / TRAINER	MEANS OF VERIFICATION	COST ESTIMATES
	- Water Sources - Water Quality - Water Harvesting - Water for Crop Production • Sanitation - Low-cost hand washing facilities - Hygiene and sanitation advocacy - Water and sanitation related diseases	• District Health Office Teams **TRAINER: Private consultant or MoHCC**	• 30 Community members	
6.	• Health and Nutrition Issues - Counselling - Balanced diet	• Extension workers in project impact areas • Community members • District Health Office Teams	In each Province: • 30 Community members • 10 Extension Workers	
	TOTAL BUDGET			**US $65 000.00**

NOTE:

- District Health Office Team are trained:
  - Environmental Health officers,
  - Nurse in Charge,
  - etc.
- Relevant line ministry trained:
  - MoHCC,
  - PIE Staff,
  - EMA,
  - MoLGPW,
  - etc.
- Community members:
  - Designated Safeguards focal point,
  - CHW,
  - Community Representatives,
  - Local Leadership,
  - Nutrition Clubs,
  - etc.

10.2.1 Proposed Approach in Executing the Training Activities

The HSDSP AF-(V) will adopt a strategy of running workshops and refresher courses to disseminate the safeguards instruments. It will also use the training of trainers and community exchange visits approach.

The training activities in Environmental and Social Impact Assessment (ESIA) can be conducted by the EMA or private consultants under the supervision of EMA. This will have to be done at the beginning of the project, before the project activities start, so that the participants are ready in time to apply the knowledge during implementation of the project activities. Skills in the screening process will be extremely useful for assessing the environmental and social implications of the project activities before they start.

Training in Project Planning and Implementation should be done before any project activities start to prepare the participants to use their knowledge during project implementation. The training should be done once during the project life. The training can be conducted by private consultants.

Specialist issues like WASH training would be facilitated internally by the HSDSP AF-(V) implementation entity, CORDAID, with the assistance from the relevant line Ministries or appropriate private consultants (Like IWSD) would have to be engaged to carry out the training. These training activities should be conducted at the beginning of the project implementation process.

10.3 BUDGET FOR CAPACITY BUILDING

The proposed environmental training activities for the project will be funded directly by the project resources in accordance with the proposed plan laid out in Table 10-1 above. A summary of the budgetary requirements for the proposed training activities is given in table 10-2 below:

Table 10-2 Summary of the Training Budgetary Requirements

No.	TRAINING ACTIVITIES		BUDGET (US $)
1.0	Environmental Social Management Framework (ESMF)and Infection Control and Healthcare Waste Management Plan (ICWMP) • healthcare workers (HCW) relevant to the project • All relevant workers involved in the Implementation of this project • Annually, job orientation and on spot	In each District: • 10 members of District Health Office Team are trained. • 5 members of each relevant line ministry trained.	**15,000.00**
2.0	Medical Waste Management i.e. • Use of the three-bin system (colour coded bins) • How to operate an incinerator • Importance of Personnel Protective Equipment (PPE) • Waste weighing and record keeping	In each District: • 10 members of District Health Office Team are trained. • 5 HCC members	**10,000.00**
3.0	Training in Environmental and Social Assessment – ESMPs of the sub-projects • High level training in Environmental and Social Risks of HSDSP AF-(V) • Training in Environmental and Social Impact Assessment • Sensitization on environmental and social management framework	In each District: • 5 members of District Health Office Team are trained. • 5 members of each relevant line ministry trained. • 5 Community members	5,000.00

	• Grievance Redress Mechanism		
4.0	Training in Water, Hygiene and Sanitation issues • Maintenance and Hygiene and Sanitation	In each District: • 5 members of District Health Office Team are trained. • 5 members of each relevant line ministry trained. • 5 Community members	5,000.00
5.0	Health and Nutrition Issues • Health facility Management • Training of VHW to execute their work and Processing facility Management	In each District: • 5 members of District Health Office Team are trained. • 5 members of each relevant line ministry trained. • 5 Community members	5,000.00
TOTAL			**US $ 45.000.00**

11. ESMF IMPLEMENTATION BUDGET

11.1 FUNDING FOR THE ENVIRONMENTAL MANAGEMENT ACTIVITIES

The following are the budget estimates for the activities in the ESMF. The Budget estimates were based on the plan that HSDSP AF-(V) will be working in:

- Eighteen (18) Rural Districts (424 health facilities) in terms of its RBF activities,
- Two (2) urban districts, (34 health facilities) in terms of its RBF activities,
- Five (5) isolation/treatment facilities for COVID-19 Response (for installation of water tank and some minor works, PPE, Ventilators),
- One hundred and four (104) hospitals only for provision of PPE),
- Ten (10) laboratories for Gene Xpert Cartridges for PCR test to diagnose COVID-19.

The budget is meant for implementing and monitoring the recommended mitigation measures throughout the project life. **The budget must be integrated into the overall programme costs to ensure that the proposed mitigation measures are implemented.**

The proposed environmental activities for the programme will be funded directly by the programme resources in accordance with the proposed plan laid out below.

11.2 SITE- SPECIFIC ESMPs

This component will comprise mitigation issues to do with Site-specific Checklist ESMPs including the development and implementation of IPPF and the Environmental License fees for registering these studies with EMA.

A number of sub-projects will be of "Moderate Risk"[20] and will require a site-specific Checklist ESMP (Appendix 11). For HCFs being financed by the HSDSP project for the first time, waste disposal facilities should be integrated into the overall design and ESMP developed.

The site-specific Checklist ESMP must be very simple. The District Environmental Officers will either draft the simple checklist ESMPs or help the project proponent to draft them, but in any case, contractors should not commence work before a checklist ESMP has been developed. The developed site-specific Checklist ESMPs will be submitted to the PIE Environmental Specialist, who will review them for completeness.

The following budget covers the allowances for District Environmental Officer to assist in the site-specific Checklist ESMP development.

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[20] "Moderate Risk Category" sub-projects are sub-projects that may have some adverse environmental and/or social impacts on human populations or environmentally significant areas, but the impacts are less adverse than those for "high Risk Category"; are site-specific and few are-irreversible in nature; and can be readily remedied by appropriate preventive actions and/or mitigation measures.

"Low Risk" Category projects generally do not require additional environmental analysis because the activities have positive environmental impacts, or negligible or minimally adverse environmental impacts.

Table 11-1 Site-specific Checklist ESMPs Budget

No.	ACTIVITY	ESTIMATED COST (US $)
1.0	Site-specific Checklist ESMPs (Develop and train beneficiaries to implement).	32,000.00
3.0	2 x Develop Indigenous Peoples Plans and train beneficiaries to implement	10,000.00
	Sub-Total	**42,000.00**

11.3 MITIGATION MEASURES

This component is for implementing mitigation measures in each district, which include: (i) prevention of soil erosion, (ii) installing WASH facilities, (iii) prevention of water-borne diseases, (iv) Prevention of GBV, (v) prevention of HIV/AIDS, (vi) COVID-19 prevention and (vi) Gender mainstreaming.

Mitigation and enhancement measures were discussed in detail in tables 6-1 to 6-4 and the following is a summary of some of the measures with cost implications. Although not listed here since each facility will need to approximate, costs associated with water quality testing before the first use of the water are an item which can be costed.

Table 11-2 Mitigation and enhancement measures Budget

No.	MITIGATION/ENHANCEMENT	ESTIMATED COST (US $)
1.0	**Capacity Building** • Capacity Assessment needs to be conducted before commencing implementation. • Intensive capacity building commensurate with proposed services/equipment • Build Social management skills for effective leadership.	15,000.00
2.0	**Stakeholder Participation** • Conduct a comprehensive participatory stakeholder mapping exercise including roles and responsibilities at national, provincial, district and local area level • Conduct adequate situational assessment to determine different vulnerability dimensions.	15,000.00
3.0	**Health Care Waste Management** • Sensitization of all health care facilities as discussed in the ICWMP i.e.: o segregate waste using the three-bin system o Handle the increased volumes of Health Care waste properly o Handle Home Based Care Waste properly.	5,000.00
4.0	• Licensing of Incinerators (10 x Emission Licenses @ $100 per license per year)	3,000.00
5.0	• Hazardous Waste transportation fees for 10 vehicles @ $10 per year for three years	300.00
6.0	• incinerator emission licences, Hazardous Waste Transportation licences, and Waste Enterprise licence (5 x 134.65 x 3)	2,020.00
7.0	**WASH Issues:** Sensitization on measures to • reduce contamination from toilets • install low-cost hand washing facilities	10,000.0
8.0	**Drinking Water Testing** • Quarterly borehole water quality Analysis for participating institutions assisted in water supply. • Monthly surface water quality Analysis for participating institutions assisted in water supply.	10,000.00
	Sub-total	**60,320.00**

11.4 MONITORING AND EVALUATION

This component provides for training both the HSDSP AF-(V) staff and the beneficiaries in participatory environmental monitoring. This entails monitoring the implementation of mitigation measures at the sub-project level. The component will comprise:

i) the monitoring and evaluation issues of the whole programme,
ii) Research and Development work to come up with more environmentally friendly, Nutrition sensitive agricultural processes,
iii) Monitoring and Evaluation of the progress of the implementation of the ESMF. Assessing whether it is being effective or not.

Table 11-3 Monitoring and Evaluation Budget

NO.	ACTIVITY	ESTIMATED COST (US $)
1.0	Monitoring and evaluation exercises	30,000.00
2.0	Research and Development work	15,000.00
	Sub-Total	**45,000.00**

11.5 ENVIRONMENTAL AND SOCIAL TRAINING

Environmental and Social Training were discussed in detail in table 11-4 and the following is a summary of the budgetary requirements for the proposed training activities. The training will be conducted by the PIE Environmental Specialist who may outsource resource persons for specialist areas like Health and Nutrition.

Table 11-4 Environmental and Social Training Budget

No.	TRAINING ACTIVITIES	BUDGET (US $)
1.0	Environmental Social Management Framework (ESMF)and Infection Control and Healthcare Waste Management Plan (ICWMP) • All healthcare workers (HCW) • All workers involved in the Implementation of this project • Annually, job orientation and on spot.	**20,000.00**
2.0	Medical Waste Management i.e. • Use of the three-bin system (colour coded bins) • How to operate an incinerator • Importance of Personnel Protective Equipment (PPE) • Waste weighing and record keeping.	**10,000.00**
3.0	Training in Environmental and Social Assessment – ESMPs of the sub-projects • High level training in Environmental and Social Risks of HSDSP AF-(V) • Training in Environmental and Social Impact Assessment • Sensitization on environmental and social management framework. • Grievance Redress Mechanism	5,000.00
4.0	Training in Water, Hygiene and Sanitation issues • Maintenance and Hygiene and Sanitation.	5,000.00
5.0	Health and Nutrition Issues • Health facility Management • Training of VHW to execute their work • Processing facility Management.	5,000.00
TOTAL		**US $ 45.000.00**

11.6 ANNUAL REVIEWS AND ANNUAL AUDITS

In addition to biannual safeguard progress reports to the WB which will be produced as part of the overall biannual project progress report, the Project will carry out reviews. which will be timed with and shared in the progress reports to the World Bank. The Project will also carry out an end of Project audit. Audits will be done bi-annually whilst reviews will be done annually after every annual report is produced.

An audit is different from a review. In a review, the auditor conducts analytical procedures and makes inquiries to ascertain whether the information contained within the annual report is correct. The result is a limited level of assurance that the annual report being presented does not require any material modifications. In an audit, the auditor must corroborate the information in the annual report. This calls for a thorough examination of all the documentation leading to the annual report, confirmations from beneficiaries, physical inspections of sub-projects and other procedures as needed.

Thus, the audit gives a higher level of assurance that the annual report is fairly presented. An audit also requires a significant amount of time and effort to complete and thus audits are much more expensive than reviews. The following is the cost estimate for the Audits.

Table 11-5 Annual Reviews

No.	ACTIVITY	ESTIMATED COST (US $)
1.0	Annual Reviews	50,000.00
	Sub-Total	**20,000.00**

11.7 ESMF IMPLEMENTATION BUDGET SUMMARY

The following is the ESMF Implementation budget summary taking into consideration all the issues covered in sections 12.1 to 12.6:

Table 11-6 Estimated Budget for ESMF Implementation (US$)

No.	YEAR / ACTIVITY	REFERENCE TABLE	YEAR 1	YEAR 2	YEAR 3	TOTAL
1	Site-specific Checklist ESMPs and Environmental License fees	Table 11-2	20,000.00	12,000.00	10,000.00	42,000.00
2	Mitigation Measures	Table 6-1 to 6-4 and 11-3	30,000.00	20,000.00	10,320.00	60,320.00
3	Monitoring and evaluation purposes (R&D, M&E, Field Visits)	Table 11-4	20,000.00	15,000.00	10,000.00	45,000.00
4	Environmental and Social Training	Table 10-2 and 11-5	20,000.00	15,000.00	10,000.00	45,000.00
5	Annual Reviews	Table 11-6	30,000.00	10,000.00	10,000.00	50,000.00
	Sub - Total					**242,320.00**
	10% Contingency					**24,232.00**
	Grand Total					**266,552.00**

Notes: Specific and clearly identified budget line for environmental and social issues should be included in the tender documents,

- 10% of contract value should be kept until the EMA officer confirms that all the environmental and social mitigation measures are appropriately implemented and the EMA has approved,
- ESIAs and ESMPs will be prepared for all sub-projects which have potential significant negative impacts, and these provide cost estimates for the implementation of specific mitigation and management measures for those sub-projects.

12. CONCLUSIONS AND UNDERTAKINGS

The proposed Health Sector Development Support Additional Financing Project (HSDSP AF-(V)) requires affective coordination and capacity building of all participating agents to foster an enabling environment for its success. As a multisectoral approach it requires active participation of all stakeholders especially those at the fore front of working with the communities, i.e., the Community Health Workers (CHW), Extension Officers, etc. Clear cut roles for all stakeholders and institutions needs to be delineated to make sure that there are no conflicts resulting from the unclear job descriptions. In this vein the PIE will analyse the operating environment at the local levels and then implement the requisite remedies for the success of the project.

The PIE will systematically apply all the available environmental and social management safeguards to ensure that the impacts on the natural and social environment are adequately identified, assessed, and minimised. The PIE Environmental Specialist together with the Communications Specialist, will ensure that all sub-projects are screened and where needed, site specific ESMPs are developed, adopted, and applied to minimise and avoid adverse impacts in all phases of subproject implementation.

The proposed project has potential to significantly improve the health delivery system in all the target areas. The improvement in health that the communities will benefit, will translate to improved livelihoods as people become productive again and this will translate ultimately to an improved economy.

The HSDSP AF-(V) project will pose more positive than negative potential environmental and social impacts. **The envisaged negative environmental and social impacts will be localized, minimal, short-term and can be mitigated by institution of simple measures.** The PIE (CORDAID) undertakes to ensure that:

- The ICWMP will be applied to deal with any resultant increase in Health Care Waste generation from the Facilities,
- Water and Sanitation issues at all facilities will be taken seriously as diarrheal disease and even the current COVID-19 pandemic, could potentially reverse all health gains that the project could have made,
- Stakeholder organizations such as EMA, NGOs and other interested developmental parties will be continuously involved and kept informed of the implementation progress so that they can play their part,
- The mitigation measures recommended in the ESMF, will be implemented to avoid any significant environmental and social impacts.

The ESMP presented in the study will be used to mitigate the impacts during and after the implementation of the HSDSP AF-(V). **The final benefits of this project to the nation will, by far, outweigh any potential negative effects. Further, the project will overall not have any significant environmental and social impacts if the recommended mitigations are carried out.**

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14. APPENDICES

APPENDIX 1 ENVIRONMENTAL AND SOCIAL SCREENING FORM

MINISTRY OF HEALTH AND CHILDCARE

ENVIRONMENTAL AND SOCIAL SCREENING FORM

FOR

SCREENING OF POTENTIAL ENVIRONMENTAL AND SOCIAL IMPACTS OF

THE HSDSP AF-(V) PROJECT

Name of Sub-project Representative:…….

Sub-project Name: ……..

Sub-project Address: ……..

…….

Name of Extension Team Representative……..

Address: ……..

…….

1.0 SITE SELECTION:

When considering the location of a sub-project, rate the sensitivity of the proposed site in the following table according to the given criteria. Higher ratings do not necessarily mean that a site is unsuitable. They do indicate a real risk of causing undesirable adverse environmental and social effects, and that more substantial environmental and/or social planning may be required to adequately avoid, mitigate, or manage potential effects.

Issues	Site Sensitivity			Rating
	Low	**Medium**	**High**	
Natural habitats[21]	• No natural habitats present of any kind	• No critical natural habitats[22] • other natural habitats occur	• Critical natural habitats present.	
Water quality and water resource availability and use	• Water resources exceed any existing demand. • Piped Water Available. • no potential water quality issues	• Water resources relatively available. • multiple water users. • water quality issues are important	• Water resources not readily available. • multiple water users. • water quality issues are important	
Natural hazards vulnerability, floods, soil stability/ erosion	• no potential stability/erosion problems. • no known volcanic/seismic/ flood risks	• some erosion potential. • medium risks from volcanic/seismic/ flood/ hurricanes	• steep slopes. • unstable soils. • high erosion potential. • volcanic, seismic or flood risks	
Physical Cultural Resources	• No known or suspected cultural heritage sites or resources	• Suspected physical cultural resources. • known physical cultural resources in broader activity area of influence	• Known physical cultural sites in project activity area	

NOTE: HSDSP AF-(V) *will not fund any project that will involve any involuntary resettlement, dam construction*

21 Natural habitats1 are land and water areas where (i) the ecosystems' bio-logical communities are formed largely by native plant and animal species, and (ii) human activity has not essentially modified the area's primary ecological functions. (see OP 4.04, Annex 1 for full definition).

22 Critical natural habitats are (1) legally protected, (2) officially proposed for protection, or (3) unprotected but of known high conservation value. (i) existing protected areas and (ii) areas officially proposed by governments as protected areas, (iii) areas initially recognized as protected by traditional local communities (e.g., sacred groves) (of known high conservation value), and (iv) sites that maintain conditions vital for the viability of these protected areas (See OP 4.04, Annex A Para.I.[b] for full definition.)

2.0 COMPLETENESS OF SUB-PROJECTS APPLICATION:

Does the sub-project application document contain, as appropriate, the following information?

	Yes	No	N/A
Description of the proposed project and where it is located			
Information about how the site was chosen, and what alternatives were considered			
A map or drawing showing the location and boundary of the project including any land required temporarily during construction			
The plan for any physical works (e.g., layout, buildings, other structures, construction materials)			
Any new access arrangements or changes to existing road layouts			
A work program for construction, operation and decommissioning the physical works, **including any site restoration needed afterwards**			
Information about measures to avoid or minimize adverse environmental and social impacts			
Details of any permits required for the project			

NOTE: HSDSP AF-(V) *will note fund any project that will involve any involuntary resettlement or dam construction.*

3.0 ENVIRONMENTAL AND SOCIAL CHECKLIST

		Yes	No	ESMF Guidance
A	**Type of activity – Will the sub-project:**			
1	Build or rehabilitate any structures or buildings?			
2	Support Health Delivery System?			
3	Be located in or near an area where there are physical cultural resources such as important historical, archaeological or cultural heritage sites?			
4	Be located within or adjacent to any areas that are or may be protected by government (e.g., national park, national reserve, world heritage site) or local tradition, or that might be a natural habitat?			
	If the answer to any of questions 1-4 is "Yes", please use the indicated Resource Sheets or sections(s) of the ESMF for guidance on how to avoid or minimize typical impacts and risks			
B	**Environment – Will the sub-project:**			
5	Potentially affect the quality of any close surface waters (e.g., rivers, streams, wetlands), or groundwater (e.g., wells)?			
6	Cause waste management difficulties (beyond known project accepted processes) or increase the risk of illness due to toxic or hazardous waste?			
7	Cause the production of construction waste which may include asbestos waste or asbestos containing materials.			
8	Cause the discharge of any pollutants into the environment such as emissions into the air due to inefficient waste treatment facilities (incinerators, etc.)?			

		Yes	No	ESMF Guidance
9	Produce, or increase the production of, solid or liquid wastes (e.g., water, medical or construction wastes)?			
	If the answer to any of questions 5-9 is "Yes", please include an Environmental and Social Management Plan (ESMP) with the sub-project's application.			
C	**Social: Gender, Land acquisition and access to resources – Will the sub-project:**			
10	Require that land (public or private) be acquired (temporarily or permanently) for its development?			
11	Displace individuals, families, or businesses?			
12	Result in and maintain adverse gender balances?			
13	Exacerbate existing gender imbalances?			
14	Positively address gender imbalances in the health sector?			
15	Include less privileged potential beneficiaries? (i.e., youths, disabled persons, child headed households, the poorest).			
16	Include disadvantaged and vulnerable groups? (i.e., ethnic minorities, Indigenous Peoples, etc.).			
D	**Cumulative Impacts – in the project area will there be:**			
17	Any current or planned development with similar impacts			
18	Any current or planned development with potential to negatively impact on the environmental and social performance of the project			
E	***Exclusion Criteria*– Will the sub-project**			
19	Result in Laboratory activities that may require Biosafety Levels 3 (BSL-3) or 4 (BSL-4) lab facilities.			
20	Cause activities that have high probability of causing serious adverse effects to human health and/or the environment not related to treatment of COVID-19 cases			

NOTE: HSDSP AF-(V) *will not fund any project that will involve any involuntary resettlement, dam construction.*
: If the answer to any of questions 11-15 is "Yes", please include an Environmental and Social Management Plan (ESMP) with the sub-projects' application

CERTIFICATION

We certify that we have thoroughly examined all the potential adverse effects of this sub-project. To the best of our knowledge, the sub-project plan as described in the application and associated planning reports (e.g., ESMF, IPP), if any, will be adequate to avoid or minimize all adverse environmental and social impacts.

SIGNATURES:

…….. **……**

EXTENSION TEAM REPRESENTATIVE **DATE**

APPENDIX 2 E & S GENERAL SUPERVISION CHECKLIST

Environmental and Social Safeguards Implementation

Ensure that documentation on specific sites and subprojects, environmental and social impacts monitoring reports, and reports on the status of safeguards implementation are furnished to the mission team at or before the kick-off meeting.

- Meet with key beneficiaries and other stakeholders,
- Review a random sample of subprojects, making sure all safeguard issues are evaluated,
- Get an overview of all the projects/sub-projects and their categories in terms of EIA,
- Identify projects with applicable environment safeguards,
- Identify projects with applicable social safeguards,
- Based on the reports, determine projects that have potential critical safeguards issues, and focus on those,
- Discuss findings and significant noncompliance issues if any with the TTL and agree on correcting actions,
- Assess the project's experience in managing social and environmental risks,
- Field visit to review recently completed subprojects, where possible review project proposals and impact monitoring records,
- Assess the use of environmental and social screening checklists contained in the Environmental and Social Management Framework (ESMF) for proposed sub-projects/investments,
- Assess implementing agencies' awareness and use of the ESMF and the ICWMP,
- Find out if there is an established ESMF/ICWMP monitoring and tracking system to ensure effective oversight of project activities at the national level,
- Identify weaknesses in procedures, internal control mechanisms, supervision, and post reviews,
- Has there been/Is there any training plan to improve the awareness and capacity of implementing agencies on the use of the ESMF and ICWMP,
- Assess the subproject implementer's capacity and commitment to plan and implement safeguard policy issues,
- Make practical recommendations for the subproject-specific action plans,
- Assess the impacts from any changes in the project design or new components. If required agree upon a revised safeguards management plan, monitoring and reporting requirements,
- Agree with the PIE on additional measures required, and if non-compliance or unresolved safeguards issues remain, establish a plan for follow on supervision.

Methodology:

- Examine sub-project design, review and approval process, social and environmental safeguards compliance, quality, and effectiveness of project outputs.

APPENDIX 3 ENVIRONMENTAL AND SOCIAL GUIDELINES FOR CONTRACTORS

The guidelines:

- covers provisions for proper management of construction sites, safe storage of construction materials and safe disposal of wastes,
- Will be included in the bidding documents and eventually be part of the contract document.

General Considerations

- The contractor shall follow the World Bank Group Environment, Health and Safety Guidelines which should become the basis for preparing the site-specific EHS Plan. For details, please refer to: www.ifc.org/EHSguidelines,
- The contractor in all his activities ensure maximum protection of the environment and the socio-economic wellbeing of the people affected by the project, whether within or outside the physical boundaries of the project area,
- Before any construction works begin, the contractor shall ensure that the relevant environmental and land acquisition certificates of authorization for the works have been obtained from the relevant authorities,
- In general, the contractor should become familiar with the environmental and social screening process. The contractor shall work in cooperation and in coordination with the Project Management Team and/or any other authority appointed to perform or to ensure that the social and environmental work is performed according to the provisions of the safeguards documents,
- The contractor shall pay close attention to health and safety requirements for workers who must wear protective clothing if required. The artisan should also ensure the health and safety of the community adjoining any construction areas,
- The contractor must ensure that all COVID -19 protocols are adhered to, and orient all staff about COVID-19 protection requirements. In particular the following must be enforced:
    - maintain physical distance of 2 meters (6') from others at all times,
    - wearing masks at all times,
    - Regular hand washing,
    - Minimum conducting of activities at close proximity,
    - Segregating construction crews and allocating tasks so that they do not overlap,
    - establishing crew shifts to be also applied for break, and lunch,
    - Meetings on site should be avoided at all times,
    - Instruction to workers should be given in open spaces and maintaining physical distance.
- In case of a chance finds of archaeological materials the contractor must adhere to the chance-find procedures (Appendix 8), which will also be part of the contract,
- The contractor shall always keep on site and make available to Environmental Inspectors or any authorized persons, copies of the ESMPs, RAPs and ARAPs for the monitoring and evaluation of environmental and social impacts and the level or progress of their mitigation,
- The contractor shall ensure that construction materials such as sand, quarry stone, soils or any other construction materials are acquired from approved suppliers and that the production of these materials by the suppliers or the contractor does not violate the environmental regulations or procedures. The contractor will restore any extraction sites prior to completing works. Site restoration is considered as part of works,

- The movement and transportation of construction materials to and within the construction sites shall be done in a manner that generates minimum impacts on the environment and on the community, as required by the ESMP,
- Construction materials shall be stored in a manner to ensure that:
    - There is no obstruction of service roads, passages, driveways, and footpaths,
    - Where it is unavoidable to obstruct any of the service paths, the contractor shall provide temporary or alternate by-passes without inconveniencing the flow of traffic or pedestrians,
    - There is no obstruction of drainage channels and natural water courses,
    - There is no contamination of surface water, ground water or the ground,
    - There is no access by public or unauthorized persons, to materials and equipment storage areas,
    - There is no access by staff, without appropriate protective clothing, to materials and equipment storage areas,
    - Access by public or unauthorized persons, to hazardous, corrosive, or poisonous substances including asbestos lagging, sludge, chemicals, solvents, oils, or their receptacles such as boxes, drums, sacks, and bags is prohibited,
- Access by staff, without the appropriate protective clothing, to hazardous, corrosive, or poisonous substances including asbestos lagging, sludge, chemicals, solvents, oils, or their receptacles such as boxes, drums, sacks, and bags is prohibited.
- Construction waste includes but is not limited to combustion products, dust, metals, rubble, timber, water, wastewater, and oil. Hence construction waste constitutes solid, liquid, and gaseous waste and smoke,
- In performing his activities, the contractor shall use the best practical means for preventing emissions of noxious or offensive substances into the air, land, and water. He shall make every effort to render any such emissions (if unavoidable) inoffensive and harmless to people and the environment. The means to be used for making the emissions harmless or for preventing the emissions shall be in accordance with the ESMPs and with the approval of the relevant Local Authority or EMA,
- The contractor shall comply with the regulations for disposal of construction/demolition wastes, wastewater, combustion products, dust, metals, rubble, and timber. Wastewater treatment and discharge will conform to the applicable regulations by the relevant guidelines,
- Asbestos wastes, PCBs and other hazardous wastes shall be treated and disposed of in conformity with the national regulations and World Bank Group standards where applicable, with the supervision of qualified personnel,
- The contractor shall protect the health and safety of workers by providing the necessary and approved protective clothing (to include at a minimum safety boots (with steel toe cap), hard hat and high visibility vest. Eye and ear protection will be required if operating power tools and dust masks if mixing concrete on site) and by instituting procedures and practices that protect the workers from dangerous operations. The contractor shall be guided by and shall adhere to the relevant national Labour Regulations for the protection of workers. Appropriate information and awareness on HIV/AIDS shall be conducted at each construction site.

APPENDIX 4 INDIGENOUS PEOPLE`S PLANNING FRAMEWORK

App 4.1 INTRODUCTION

This Indigenous Peoples Planning Framework (IPPF) has been prepared to ensure that the World Bank's Indigenous Peoples Policy (OP4.10) is applied to HSDSP AF-(V)-supported projects. The objectives of the policy are to avoid adverse impacts on Indigenous Peoples and to provide them with culturally appropriate benefits.

The Indigenous Peoples policy recognizes the distinct circumstances that expose Indigenous Peoples to different types of risks and impacts from development projects. As social groups with identities that are often distinct from dominant groups in their national societies, Indigenous Peoples are frequently among the most marginalized and vulnerable segments of the population. As a result, their economic, social, and legal status often limit their capacity to defend their rights to lands, territories, and other productive resources, and restricts their ability to participate in and benefit from development. At the same time, the policy, together with the Involuntary Resettlement policy, recognizes that Indigenous Peoples play a vital role in sustainable development and emphasizes that the need for conservation should be combined with the need to benefit Indigenous Peoples to ensure long-term sustainable management of critical ecosystems.

The IPPF describes the policy requirements and planning procedures that sub-projects of HSDSP AF-(V) will follow during their preparation and subsequent implementation. It also describes the role of HSDSP AF-(V).

App 4.2 HSDSP AF-(V) AND INDIGENOUS PEOPLES

Some of the Health Facilities where HSDSP AF-(V) will invest serve areas or territories traditionally owned, customarily used, or occupied by Indigenous Peoples (IPs). The potential impacts of the project, both negative and positive will directly affect the IPs impacting on their intrinsic ways of life and their healthy ecosystems on which they depend for their survival. Therefore HSDSP AF-(V) sub-projects can provide valuable long-term opportunities for sustainable development for Indigenous Peoples and other local communities if the positives of the project are implemented. However, several risks are relevant for the type of projects supported by HSDSP AF-(V):

- **Customary and Indigenous Peoples' rights:** Rights of Indigenous Peoples are recognized in international agreements and for World Bank-supported projects by the Bank's own policy. Such rights may also be recognized in national legislation. HSDSP AF-(V) sub-projects will need to identify and recognize these rights to ensure that activities are not adversely affecting such rights.
- **Loss of culture and social cohesion**: Given Indigenous Peoples' distinct cultures and identities and their frequent marginalization from the surrounding society, interventions may run the risk of imposing changes to or disruption of their culture and social organization, whether inadvertently or not. This can happen if the participation of the IPs is not appropriate:

- The engagement techniques used are not cultural appropriate, causing the IPs to hold back since they may have special cultural requirements for engagement or even service delivery.
- Inappropriate selection of methods for disclosure of information (including such topics as format, language, and timing).
- Inappropriate selection of location and timing for engagement event(s) (avoiding busy work times, which may be seasonal, and days/times when special events may be occurring).
- Not agreeing on the mechanisms for ensuring stakeholder attendance at engagement event(s) (if required).
- Failure to identify the appropriate feedback mechanisms to be employed.

While indigenous communities may welcome and seek change, they can be vulnerable when such change is imposed from external forces and when such change is rushed.

- **Inequitable participation**: The level of participation which the IPs will be afforded may not yield the intended results because:
  - The local communities may not see the benefit of taking their time and resources to participate in project activities when they do not expect to receive culturally appropriate benefits.
  - The design of the participation may not include appropriate capacity building (when needed) or take into consideration local decision-making structures and processes with the risk of leading to alienation of local communities or even conflicts with and/or between local communities.
  - Participation design may not include appropriate representation of Indigenous Peoples in decision-making bodies.

  This can be averted by conducting specific targeting of stakeholder engagement activities relevant to Indigenous Peoples (IPs) that meet the requirements of OP4.10. This may involve carrying out a Social Assessment (SA) prior to any activities that would impact on them, coming up with a stand-alone plan or framework of how to deal with the IPs and developing site-specific approaches that will ensure adequate consideration of their specific cultural needs in accordance with OP 4.10.

Projects affecting Indigenous Peoples, whether adversely or positively, therefore, need to be prepared with care and with the participation of affected communities. The requirements include social analysis to improve the understanding of the local context and affected communities; a process of free, prior, and informed consultation with the affected Indigenous Peoples' communities in order to fully identify their views and to obtain their broad community support to the project; and development of project-specific measures to avoid adverse impacts and enhance culturally appropriate benefits.

App 4.3 POLICY REQUIREMENTS

The level of detail necessary to meet the requirements is proportional to the complexity of the proposed project and commensurate with the nature and scale of the proposed project's potential effects on the Indigenous Peoples, whether adverse or positive. This needs to be determined based on a subjective assessment of project activities, circumstances of local communities, and project impacts.

Minimum requirements for projects working in areas with Indigenous Peoples are identification of Indigenous Peoples and assessment of project impacts, consultations with affected communities, and development of measures to avoid adverse impacts and provide culturally appropriate benefits (in projects with no impacts this could be limited to consultations during implementation to keep local communities informed about project activities).

App 4.3.1 Screening for Indigenous Peoples.

The HSDSP AF-(V) PIE will know if Indigenous Peoples are present in a sub-project area and can proceed to the social assessment and consultations (see next section).

However, if this is not the case HSDSP AF-(V) sub-project applicants (the Health Facilities) are required to screen for the presence of Indigenous Peoples early on in project preparation, using the screening form (Appendix 1). The characteristics of Indigenous Peoples (a distinct, vulnerable, social, and cultural group)[23] mentioned in OP 4.10 will be used. Health Facilities in Tshsolotsho, Bulalima-Mangwe, Guruve and Mbire Districts can confirm by screening if they are not sure of the presence of the IPs in their areas since the two peoples who self-identify as indigenous in Zimbabwe are found[24].

App 4.3.2 Social assessment

Once it has been determined that Indigenous Peoples are present in the project area, the applicant assesses the circumstances of affected indigenous communities and assesses the project's positive and adverse impacts on them. This is to ensure that the project design takes IP needs and views into account. The level of detail of the assessment depends on project activities and their impacts on local communities. If the project is small and has no or few adverse impacts, this assessment is done as part of early project preparation by the applicant, mainly based on secondary sources and the applicants own experience working in the area. In larger and more complex projects, the assessment may be a separate exercise done by the applicant or contracted experts as appropriate and may include primary research (Note that the assessments for large projects is not envisaged in this Project). In all cases the assessment will be based on consultations with the affected communities.

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23 "Indigenous Peoples" are a distinct, vulnerable, social, and cultural group possessing the following characteristics in varying degrees:

(a) self-identification as members of a distinct indigenous cultural group and recognition of this identity by others.
(b) collective attachment to geographically distinct habitats or ancestral territories in the project area and to the natural resources in these habitats and territories7
(c) customary cultural, economic, social, or political institutions that are separate from those of the dominant society and culture.
(d) an indigenous language, often different from the official language of the country or region.

24 The Indigenous Peoples of Zimbabwe are the:

i) Tshwa (Tyua, Cuaa) San, who are found in the Tsholotsho District of Matabeleland North Province and the Bulalima-Mangwe District of Matabeleland South Province in western Zimbabwe
ii) Doma (Wadoma, Vadema) of Chapoto Ward in Guruve District and Mbire District of Mashonaland Central Province and Karoi District of Mashonaland West Province in the Zambezi Valley of northern Zimbabwe.

The main purpose of the social assessment is to evaluate the project's potential positive and adverse impacts on the affected Indigenous Peoples. It is also used to inform project preparation to ensure that project activities are culturally appropriate, will enhance benefits to target groups, and is likely to succeed in the given socioeconomic and cultural context. In this way the assessment informs the preparation of the design of the project as well as any measures and instruments needed to address issues and concerns related to Indigenous Peoples affected by the project.

The findings of the social assessment are described in a separate report and reflected in the sub-project proposal application. For small scale projects with no direct impacts on indigenous communities, the report is short and includes a brief overview of the indigenous communities affected by the sub-project, project activities as they relate to the local communities, how project implementation will address the circumstances of Indigenous Peoples, and how they will participate and be consulted during implementation.

For more complex projects a more elaborate report is required and should include the following elements, as needed:

- A description, on a scale appropriate to the project, of the legal and institutional framework applicable to Indigenous Peoples,
- Baseline information on the demographic, social, cultural, and political characteristics of the affected indigenous communities, and the land and territories which they traditionally owned, or customarily used or occupied and the natural resources in which they depend,
- Description of key project stakeholders and the elaboration of a culturally appropriate process for consultation and participation during implementation,
- Assessment, based on free, prior, and informed consultation with the affected Indigenous Peoples' communities, of the potential adverse and positive effects of the project. Critical to the determination of potential adverse impacts is an analysis of the relative vulnerability of, and risks to, the affected indigenous communities given their distinct circumstances, close ties to land, and dependence on natural resources, as well as their lack of opportunities relative to other social groups in the communities, regions, or national societies they live in,
- Identification and evaluation, based on free, prior, and informed consultation with the affected Indigenous Peoples' communities, of measures to ensure that the Indigenous Peoples receive culturally appropriate benefits under the project and measures necessary to avoid adverse effects, or if such measures are not feasible, identification of measures to minimize, mitigate, or compensate for such effects.

App 4.3.3 Free, prior, and informed consultation

The Applicant undertakes a process of free, prior and informed consultation with the affected Indigenous Peoples' communities during project preparation to inform them about the project, to fully identify their views, to obtain their broad community support to the project, and to develop project design and safeguard instruments. In most cases, this process is best done as part of the social assessment although consultations are likely to continue after its completion.

The extent of consultations depends on the project activities, their impacts on local communities and the circumstances of affected Indigenous Peoples. At a minimum (for projects with no impacts or direct interventions with the indigenous communities), local communities (villages or dwellings neighbouring the Health Facility, Staff of the Health Facility, and other potential Clients of the Health Facility) are informed about the project, asked for their views on the project, and assured that they will not be affected during project implementation. For projects affecting indigenous communities, whether positively or adversely, a more elaborate consultation process is required. This may include, as appropriate:

- Inform affected indigenous communities about project objectives and activities,
- Discuss and assess possible adverse impacts and ways to avoid or mitigate them,
- Discuss and assess potential project benefits and how these can be enhanced,
- Identify and discuss (potential) conflicts with other communities and how these might be avoided,
- Elicit and incorporate indigenous knowledge into project design,
- Facilitate and ascertain the affected communities' broad support to the project,
- Develop a strategy for indigenous participation and consultation during project implementation, including monitoring and evaluation.

All project information provided to indigenous peoples should be in a form appropriate to local needs. Local languages should usually be used, and efforts should be made to include all community members, including women and members of different generations
and social groups (e.g., clans and socioeconomic background).

The applicant is responsible for the consultation process. The consultation process for the Tshwa Communities will generally take the following form:

- Identify appropriate customary approaches to deal with the communities in question,
- Using the identified approaches, inform the affected indigenous communities about project objectives and activities,
- Identify the elected and natural leaders in these communities who will be used as representatives as the project progresses,
- Discuss and assess possible adverse impacts and ways to avoid or mitigate them,
- Discuss and assess potential project benefits and how these can be enhanced,
- Discuss and assess the Health Facilities at their disposal and the most appropriate ways they can derive benefits from them,
- Identify and discuss (potential) conflicts with other communities in the use of these Facilities and how these might be avoided,
- Elicit and incorporate indigenous knowledge into project design,
- Facilitate and ascertain the affected communities' broad support to the project,
- Develop a strategy for indigenous participation and consultation during project implementation, including monitoring and evaluation.

However, if the communities in question are organized in community associations or umbrella organizations, these should usually be consulted. In some cases, it may be appropriate or even necessary to include or use in the process independent entities that have the affected

communities' trust. The experience of (other) locally active NGOs and Indigenous Peoples experts may also be useful.

When seeking affected indigenous communities' support to project activities, two aspects should be considered: Who and what is the "community," and how is "broad support" obtained. Communities are complex social institutions and may be made up of several fractions; it may be difficult finding persons who are representatives of the community. Interest in the project may vary among different groups (and individuals) in the community, and they may be affected differently. It is important to keep this in mind during the consultation process, and in some cases, it may be more appropriate to consider the needs and priorities of sub-communities rather than those of a whole village.

When seeking "broad community support" for the project, it should be ensured that all relevant social groups of the community have been adequately consulted. When this is the case and the "broad" majority is overall positive about the project, it would be appropriate to conclude that broad community support has been achieved. Consensus building approaches are often the norm, but "broad community support" does not mean that everyone must agree to a given project. The agreements or special design features providing the basis for broad community support should be described in the Indigenous Peoples Plan; any disagreements should also be documented.

App 4.3.4 Indigenous Peoples Plan

Based on the consultation and social assessment processes, project design is refined, and measures and instruments are prepared to address issues pertaining to Indigenous Peoples. The documents are prepared with the participation of affected indigenous communities during the consultation process.

The instrument to address the concerns and needs of Indigenous Peoples is usually an Indigenous Peoples Plan (IPP). HSDSP AF-(V) will facilitate the development of the sub-project specific IPPs for onward submission to the Bank for review and approval sub-project specific IPPs. In cases where Indigenous Peoples are the sole or most direct project beneficiaries, the elements of an IPP should be included in the overall project design, and a separate IPP is not required. In this case the project application becomes the IP and must respond to the requirements outlined in the above.

It should be noted that very few HSDSP AF-(V) sub-projects are likely to need such an elaborate plan. It may be appropriate to include a process of further social analysis and consultations during project implementation to determine specific activities (this is particularly so given the limited funds for preparing HSDSP AF-(V) projects). At minimum the IPP should include a description of the Indigenous Peoples affected by the project; summary of the proposed project; detailed description of the participation and consultation process during implementation; description of how the project will ensure culturally appropriate benefits and avoid or mitigate adverse impacts; a budget; mechanism for complaints and conflict resolution; and the monitoring and evaluation system that includes monitoring of particular issues and measures concerning indigenous communities.

The following elements and principles may be included in the IPP, as appropriate:

- Specific measures for implementation, along with clear timetables of action, and financing sources. These should be incorporated into the general project design as appropriate. Emphasis should be on enhancing participation and culturally appropriate benefits. Adverse impacts should only be contemplated, when necessary,
- Formal agreements reached during the free, prior, and informed consultation during project preparation,
- Clear output and outcome indicators developed with affected Indigenous Peoples,
- Project design should draw upon the strengths of Indigenous Peoples Organizations and the IP communities and consider their languages, cultural and livelihood practices, social organization, and religious beliefs. It should avoid introducing changes that are considered undesirable or unacceptable to the Indigenous Peoples themselves,
- Efforts should be made wherever possible and appropriate to make use of, and incorporate, Indigenous knowledge and local resource management arrangements into project design,
- Special measures for the recognition and support of customary rights to land and natural resources may be necessary,
- Special measures concerning women and marginalized generational groups may be necessary to ensure inclusive development activities. If the grantee does not possess the necessary technical capacities, or if their relationship with Indigenous Peoples is weak, the involvement of experienced local community organizations and NGOs may be appropriate; they should be acceptable to all parties involved,
- Capacity building of other implementing agencies should be considered,
- Capacity building activities for the indigenous communities to enhance their participation in project activities may be useful or necessary; this may also include general literacy courses,
- Grievance mechanism considering local dispute resolution practices,
- Participatory monitoring and evaluation exercises adapted to the local context, indicators, and capacity.

App 4.4 DISCLOSURE

Before finalizing an IPP (or IPPF) a draft should be disclosed together with the social assessment report (or its key findings) in a culturally appropriate manner to the Indigenous Peoples affected by the project. Language is critical and the IPP should be disseminated in the local language or in other forms easily understandable to affected communities – oral communication methods are often needed to communicate the proposed plans to affected communities.

The HSDSP AF-(V) will then disclose the IPP (or IPPF) with the Bank. After the Bank has reviewed and approved the IPP (or IPPF) as part of the overall proposed project for funding, the sub- project (HSDSP AF-(V)) will share the final IPP (or IPPF) again with the affected communities. The final IPP (or IPPF) is will also be disclosed at the HSDSP AF-(V) Web site.

App 4.5 ROLES AND RESPONSIBILITIES

Sub-project applicants are responsible for following the requirements of this Framework. They will ensure that Indigenous Peoples are consulted and benefit in culturally appropriate ways. They will avoid adverse impacts on indigenous communities, or where this is not possible develop with the participation of affected communities, measures to mitigate and compensate for such impacts. Finally, they are responsible for reporting to both affected indigenous communities and HSDSP AF-(V) on project progress and any unexpected and unintended events affecting Indigenous Peoples.

HSDSP AF-(V) is responsible for the implementation of this Framework and will ensure that the participation of Indigenous Peoples in project activities in culturally appropriate ways is encouraged. HSDSP AF-(V) responsibilities include:

- Inform applicants and other stakeholders, including local communities, of this Framework and policy requirements,
- Assist applicants, and subsequently grantees, in the implementation of the Framework and policy requirements,
- Screen for projects affecting Indigenous Peoples.
- Review and approve project proposals, ensuring that they adequately apply the World Bank's Indigenous Peoples Policy,
- Assess the adequacy of the assessment of project impacts and the proposed measures to address issues pertaining to affected indigenous communities. When doing so project activities, impacts and social risks, circumstances of the affected indigenous communities, and the capacity of the applicant to implement the measures should be assessed. If the risks or complexity of issues,
- Assess the adequacy of the consultation process and the affected indigenous communities' broad support to the project—and not provide funding until such broad support has been ascertained and
- Monitor project implementation, and include constraints and lessons learned concerning Indigenous Peoples and the application of this IPPF in its progress and monitoring reports; it should be assured that affected indigenous communities are included in monitoring and evaluation exercises.
-

App 4.6 GRIEVANCE MECHANISM

Indigenous Peoples and other local communities and stakeholders may always raise a grievance to sub-project applicants and HSDSP AF-(V) about any issues covered in this Framework and the application of the Framework. Affected communities should be informed about this possibility and contact information of the respective organizations at relevant levels should be made available. These arrangements should be described in the project-specific frameworks and action plans along with the more project-specific grievance and conflict resolution mechanism.

As a first stage, grievances should be made to the sub-project applicants, who should respond to grievances in writing within 15 working days of receipt. Claims should be filed, included in project monitoring, and a copy of the grievance should be provided to the HSDSP AF-(V) PIE. If the claimant is not satisfied with the response, the grievance may be escalated to MoHCC Head office.

APPENDIX 5 STAKEHOLDER ENGAGEMENT PROCESS

This appendix contains the details of the field consultations and the Stakeholder Validation Workshop, that were conducted for the development of the ESMF.

APP 5.1 FIELD PUBLIC CONSULTATION

The following is an outline of the Public Consultation that was carried out in August 2020 for the development of the ESMF. Consultations were done in Mashonaland EAST, Harare, Bulawayo, Matabeleland South, and Matabeleland North. Table APP 5.1 is the list of the stakeholders who were met during the Field consultation process.

Table APP 5.1 List of Consulted Stakeholders from field visits.

No.	MEETING DATE	NAME	ORGANIZATION	DESIGNATION	Contact No. & Email Address
2.0	**MASHONALAND EAST**				
2.1	**Mashonaland east PMD MEETING**				
2.1.1	21/08/20	Edmore Mutsinze	Cordaid	Officer	0779660 Edmore.mutsinze@cordaid
2.1.2	21/08/20	Paul Matsvimbo	MoHCC	Officer	0772855029 pfmatsvimbo@gmail.com
2.1.3	21/08/20	Godwin Chibvuura	MoHCC	DR	0772406273 gchibvuura@gmail.com
2.1.4	21/08/20	Laizah Chourombo	MPSLSW	OFFICER	0782118242 ichourombo@gmail.com
2.1.5	21/08/20	T. Mapengo	MLGPW	Officer	terrificcee@yahoo.com
2.1.6	21/08/20	Juliet Mavu	EMA	Officer	Juliet.mavu@ema.co.zw
2.1.7	21/08/20	Dube MC	MLG.PW	Officer	Dubecharles36@gmail.com
2.1.8	21/08/20	Matsitsiro Alfred	Municipal of Marondera	Director	matsitsiroalfred@yahoo.com
2.1.9	21/08/20	Boniface Machingauta	MoHCC	Officer	bmachingauta@yahoo.com
2.1.10	21/08/20	Karetu Admire	MoHCC	Officer	ndaramukaretu@yahoo.com
2.1.11	21/08/20	Eunice Takura	MoHCC	Officer	Eunicetakura25@gmail.com
2.2	**Marondera District Hospital**				
2.2.1	21/08/20	Kamba Mercy	MoHCC	DR	0772819364 kambamercy@gmail.com
2.2.2	21/08/20	C Dhege	MoHCC	DR	0772434162 cdhege64@gmail.com
2.2.3	21/08/20	A Mutsinze	cordaid	officer	Amutsinze64@gmail.com
2.2.4	21/08/20	E Mutsikiwa	MoHCC	officer	emutsikiwa@gmail.com
2.2.5	21/08/20	Juliet Hungwa	MoHCC	Officer	jhungwa@yahoo.com
2.3	**Mahusekwa District Hospital**				
2.3.1	21/08/20	Alfred Mhlanga	MoHCC	Officer	alimhlanga@gmail.com
2.3.2	21/08/20	P Mutubuki	MoHCC	Officer	Pmutubuki27@gmail.com
2.3.3	21/08/20	Munodawafakudzai	MoHCC	Officer	kudzaimudavanhu@gmail.com
2.3.4	21/08/20	Kuvelatawanda	MoHCC	OFFICER	tkuveya@gmail.com
2.3.5	21/08/20	Madoro	MoHCC	DR	dytief@gmail.com
2.4	**Chiota Clinic**				
2.4.1	21/08/20	Kutema	MoHCC	Sister	kutemafary@gmail.com
2.4.3	21/08/20	Chikuniwo	MoHCC	Sister	gamuchikuniwo@gmail.com
2.4.4	21/08/20	Virginia Marondeza	MoHCC	Sister	veemurondeza@gmail.com

No.	MEETING DATE	NAME	ORGANIZATION	DESIGNATION	Contact No. & Email Address
2.4.5	21/08/20	Mutume SHUPIKAI	MoHCC	SISTER	N/A
2.4.6	21/08/20	Mufambi Regina	MOHCC	NURSE aid	reginamufambi@gmail.com
3.0	**HARARE**				
3.1	**Wilkins hospital**				
3.1.1	28/08/20	Andrew Tapera	MoHCC	Admin	0773392220 atapera@yahoo.com
3.1.2	28/08/20	Rhoda Dzawara	MoHCC	Srn	0773286166 rhodadzawie@gmail.com
3.2	**Edith Operman Mbare Clinic**				
3.2.1	28/08/20	Chirau B	City of Harare Mbare poly	Sic	0774151759 75-282469 v 75
3.2.2	28/08/20	Mutandwa V	City of Harare Mbare poly	a/sic	0773836534 63-1064493q 38
3.2.3	28/08/20	Mkahanana P	City of Harare Mbare community	SIC Community Services	15-058402 c 15 0772628991
3.3	**HCC Mbare**				
3.3.1	28/08/20	Chackie Makaza	Mbare community	HCC Chairman	0772415722 64-448011 D 63
4.0	**BULAWAYO**				
4.1	**BULAWAYO - PMD**				
4.1.1	25/08/20	Mlilo W	MoHCC	a/pmd	0776435501 Welly.mlilo@gmail.com
4.1.2	25/08/20	Hove S	Byo city	CNO	0712745533 sthove@citybyo.co.zw
4.1.3	25/08/20	Malaba C	City of byo	ADE	0773187724 cmalaba@citybyo.co.zw
4.1.4	25/08/20	Siziba S	City of byo	SNPO	0772402425 sisiziba@citybyo.co.zw
4.1.5	25/08/20	Dzoma F	Social welfare	PSWD	0773299563 dzomafanwell@gmail.com
4.1.6	25/08/20	'Ndlovu D	EMA	Manager	0712832259 decent.ndlovu@ema.co.zw
4.1.7	25/08/20	Nyathi K –	City of Bulawayo	ADHS(PH)	0776248128 d.knyathi@citybyo.co.zw
4.1.8	25/08/20	Kavu C	LOCAL Government	PAO	0718912611 chipokavu@gmail.com
4.1.9	25/08/20	P Munyaka	Local Government	PAO	0772478689 pardonmunyaka@gmail.com
4.2	**THORNEGROOVE CLINIC**				
4.2.1	25/08/20	S V. Ndiweni	MoHCC	Nurse	n/a
4.2.2	25/08/20	N Dhodho	MoHCC	Nurse	292266746 thornegroovehospital@gmail.com
4.2.3	25/08/20	V.S. Ndlovu	MoHCC	Nurse	n/a
4.2.4	25/08/20	N Sibanda	MoHCC	Nurse	292 66746

No.	MEETING DATE	NAME	ORGANIZATION	DESIGNATION	Contact No. & Email Address
4.3	**MPILO CENTRAL HOSPITAL**				
4.3.1	27/08/20	Peggie Lungu	MoHCC	Srn matron	0772903523 lungupeggie@gmail.com
4.3.2	27/08/20	Nkomo Nokuthula	MoHCC	Srn	Nokuthulagobvu16@gmail.com 0772884171
4.4	**UBH**				
4.4.1	27/08/20	Sithembiso Joyce Baleni	MoHCC	Srn IPC	sithmbisobaleni@gmail.com 0776865866
4.5	**MAQHQWE CLINIC**				
4.5.1	27/08/20	Stella Nyoni	CITY OF BYO	NURSE	nyonistella05@smail.com 0712440726
4.5.2	27/08/20	Sithokozile Ncube	CITY OF BYO	NURSE	sithokozilekamombe@gmail.com 0775708937
4.5.3	27/08/20	C Sibanda	City of byo	Srn	0772362660 sibandac@citybyo.co.zw
4.5.4	27/08/20	R Dzemaema	City of byo	Srn	rdzemaema@city.co.zw 0773511455
4.5.5	27/08/20	S Sibanda	City of byo	Srn	siksibanda@citybyo.co.zw 29266420
4.6	**CBO and HCC Maqhawe Nkulumane**				
4.6.1	27/08/20	Nhlanhla K	nkulumane	Cbo officer	0779014874 08-2144907 r 21
4.6.2	27/08/20	Khumalo B	nkulumane	Cbo officer	0771155243 08-2143390 s 21
4.6.3	27/08/20	Zulu P	nkulumane	Hcc	0777015227 08-109635 v39
4.6.4	27/08/20	N Kumalo	nkulumane	Hcc	0772681954 08-516771 j 73
4.6.5	27/08/20	C Dezidere	nkulumane	Hcc	0775668033 29-011287903
4.6.6	27/08/20	C N Zulu	nkulumane	Cbo officer	0718979475 08-2053681 h21
4.6.7	27/08/20	S Chiukuse	nkulumane	Hcc	0773577674 08-37635 c71
4.6.8	27/08/20	Guhwa C	nkulumane	Hcc	0773516794 08-491140 z 05
4.6.9	27/08/20	S Sithole	nkulumane	Cbo	0772872957 73-076919 h 73
4.6.10	27/08/20	M Mase	nkulumane	Hcc	0773886868 08-118434 j 41
5.0	**MATABELELAND SOUTH**				
5.1	**Matabeleland South – PMD Meeting**				
5.1.1	25/08/20	Rudo Chikohore	MoHCC	Pmd	0772650876
5.1.2	25/08/20	Joyce Sibanda	MoHCC	Pmd	0772477890
5.2	**Gwanda PDC**				
5.2.1	24/08/20	NYAKUDYA	Social Welfare	Dsw Officer	criswellnyakudya@yahoo.com

No.	MEETING DATE	NAME	ORGANIZATION	DESIGNATION	Contact No. & Email Address
					0772929332
5.2.2	24/08/20	Sithembisiwe Ndhlovu	EMA	PROVINCIAL MANAGER	0779880544/0712832261 sithembisiwendlovu@ema.co.zw
5.2.3	24/08/20	Sithandiwe Ncube	PDC	PAC	Ndumosithandisiwe2@gmail.com 0775671235
5.2.4	24/08/20	Ncube S H	MLGPW	PPWD	siyaysan@gmail.com 0772407452
5.2.5	24/08/20	Nyathi A	INFORMATION OFFICER	MIN OF INFORMATION	anyathi04@gmail.com
5.2.6	24/08/20	Ndlovu Gift	MoHCC	EHT	Ndlovugift79@gmail.com 0772960228
5.3	**Mangwe DDC Meeting (Plumtree)**				
5.3.1	26/08/20	Nganunu Joe	MoHCC	a/dmo	0772756458 nganunujoe@gmail.com
5.3.2	26/08/20	Majonga N	MLGPW	Pao	0775107227 majonga@gmail.com
5.3.3	26/08/20	Magiga R	Council	Town planner	0772979324 Gigast2@gmail.com
5.3.4	26/08/20	Tshuma K	council	EHO	0776177354 ktshuma91@gmail.com
5.3.5	26/08/20	Ndlovu Nl	DDF	Water technician	0784171328 inmatwasa@gmail.com
5.3.6	26/08/20	Matshazi C T	MoHCC	PEHT	0773724938 clarencematshazi@gmail.com
5.3.7	26/08/20	Chapanduka A	MoHCC	Accountant	0772962857 achapanduka@gmail.com
5.3.8	26/08/20	Bridget Masuka	MoHCC	DNSH	0772346090 bridgetmasuka@gmail.com
5.3.9	26/08/20	Tsoelopele Dube	MoHCC	**SICC**	0774667302 tsoedubenove@gmail.com
5.3.10	26/08/20	Sikhumbuzo Nohovu	MoHCC	**VNO 2**	0773535008 sikhumbuzo62@gmail.com
5.3.11	26/08/20	Togara O	Local Government	A/DDC	0773686740 ozogarah@gmail.com
5.3.12	26/08/20	Sibanda P	MoHCC	EHO	0772544484 patricksibandap@yahoo.com
5.3.13	26/08/20	Xaba N	MoHCC	EHO	0777548897 nduexaba@gmail.com
5.3.14	26/08/20	Mlambo P	PCU	PRBFO	0779660844 Pharaoh.mlambo@cordaid.org
5.3.15	26/08/20	Moyo T	MoHCC	DTLC	0772365684 Moyotan9@gmail.com
5.3.16	26/08/20	Hapanyengwi E	MoHCC	DMO	0772907621 drerasmus@gmail.com
5.3.17	26/08/20	Ndlovu P	MOHCC	PROVINCIAL IPC /SNO 3 ST ANNES MATRON	0772857925 patieencendlovini@gmail.com
5.3.18	26/08/20	Nyathi S	Social development	DSDO	0774779660 scele2007@gmail.com
5.4	**Marula Clinic**				
5.4.1	28/08/20	'Sibanda Sidumisile	MOHCC	S R NURSE	sduesibanda90@gmail.com 0775522822
5.4.2	28/08/20	'Mnkandla Siphunyuziwe	MOHCC	SR NURSE	0771907374
5.4.3	28/08/20	Nesia Ncube	MOHCC	SRNURSE	0777153272

No.	MEETING DATE	NAME	ORGANIZATION	DESIGNATION	Contact No. & Email Address
					nesiancube@gmail.com
5.5	**CBO Marula Mahole Village**				
5.5.1	28/08/2020	Dabsondube	Village cbo chairman	Farmer	0775759625/0717655458
6.0	**MATABELELAND NORTH**				
6.1	**Tsholotsho Hospital**				
6.1.1	25/08/20	Mwiya Moonga	Tsholotsho Hosp	DNO	0772673760
6.1.2	25/08/20	Mbonisi Ncube	Tsholotsho Hosp	DEHO	0773494888
6.1.3	25/08/20	Sibonile Nkala	Tsholotsho Hosp	Matron	0772321541
6.1.4	25/08/20	Charity Bhebhe	Sikente Clinic	NIC	0774401264
6.1.5	25/08/20	Orpa Ruzawe	EMA Tsholotsho	EMA officer	0772468494
7.2	**Sikente clinic**				
6.2.1	26/08/20	Joyce Ndlovu	Village 1	Villager	Village 1 I.D.No. 73-014074-Y-73 0778 874 218
6.2.2	26/08/20	Concilia Moyo	Jalume **Village**	Villager	Jalume **Village** I.D.No. 73-045812-W-73 0774 342 438
6.2.3	26/08/20	Silingiwe Ndlovu	**Sikente clinic**	VHW	Jalume **Village** I.D.No. 73-054032-F-73 0784 265 904
6.2.4	26/08/20	Ritah Ndlovu	**Sikente clinic**	VHW	Landelani **Village** 79-031710-G-79 0779 349 735
6.2.5	26/08/20	Cecilia Thwala	Landelani **Village**	Villager	Landelani **Village** I.D.No. 08-448586-V-53 0784 265 916
6.2.6	26/08/20	Philani Moyo	Landelani **Village**	Villager	Landelani **Village** I.D.No. 73-014985-H-73 0778 785 197
6.2.7	26/08/20	Grace Ncube	**Sikente clinic**	VHW	Village 1 I.D.No. 08-665449-C-73 0782 310 735
6.2.8	26/08/20	Tendai Nyandoro	Jalume **Village**	Villager	Jalume **Village** I.D.No. 27-049000-L-23 0779 843 287
6.2.9	26/08/20	Thunyiwe Dube	**Sikente clinic**	VHW	Village 3 I.D.No. 56-038421-B-21 0775 261 465

APP 5.2 STAKEHOLDER ENGAGEMENT

The consultations with the designated implementing or major organizations involved mainly the administration of the questionnaire, meetings, and interviews.

In general, the aims of the consultations included (i) introducing the project to the Stakeholders; (ii) jointly identifying the potential environmental and social challenges the project may face; (iii) identifying any other possible challenges and how they should be addressed or mitigated; and (iv) bringing on board the major stakeholders to garner project ownership from inception. The institutions that were visited are grouped in the table below and the proof of public consultations that follows takes an example of each of the groups.

Table APP 5.2 Consulted Institutions

No.	STAKEHOLDER GROUPING	CONSULTED INSTITUTIONS
1	Client Organisations	• Inception Meeting.
2	Participating Ministries and Agencies	• MoHCC, • EMA.
3	Provincial Development Committee (PDC) Made up of public works pa, EMA, police, health etc	• Gwanda PDC, • Marondera PDC, • Bulawayo PDC, • Hararae PDC.
4	Provincial Medical Director (PMD)	• Mashonaland east PMD, • BULAWAYO – PMD, • Matabeleland South – PMD Meeting, • Harare.
5	District Development Committee (DDC)	• Mangwe DDC (Plumtree), • mahusekwa, • Harare.
6	Central/Referral Hospital	• MPILO CENTRAL HOSPITAL, • UBH district hospital, • Harare (Sally Mugabe).
7	COVID Designated Hospitals	• Wilkins Hospital, • Mahusekwa Hospital, • Thorngroove Hospital.
8	Isolation Centre	• Wilkins, • Thorn groove • Mahusekwa • Plumtree.
9	Provincial Hospital	• Marondera.
10	District Hospitals	• Mahusekwa district hospital, • Gwanda Hospital, • Plumtree district.
11	Urban Clinics	• Edith Operman Mbare Clinic, • Maqhqwe Clinic.
12	Rural Clinics	• Chiota Clinic, • Marula Clinic, • Sikente clinic.
13	CBO/HCC	• CBO Marula Mahole Village, • CBO and HCC Maqhawe Nkulumane, • HCC Mbare.

Since the HSDSP AF-(V) will be a nation-wide project, five out of the ten Provinces were selected for Consultations and the strategy that was applied included the following:

- Limited site visits:
  - Mashonaland East, Harare, Bulawayo, Matabeleland South, and Matabeleland North were sampled for site visits,
  - In each province a central hospital, Provincial Hospital, District Hospital, Clinic, COVID designated Hospital, Isolation Centre, etc were visited and staff at different levels interviewed,
  - Also participating Government Ministries and Agencies like Ministry of Local Government and the Environmental Management Agency (EMA) were also visited,
  - As the situation allowed, face to face interviews, completion of Questionnaires and focus group meetings were conducted.
- Several Virtual Zoom Meetings were made with some of the key stakeholders like MoHCC management, EMA Head office, etc,
- Administration of an electronic Questionnaire was done to all key stakeholders in MoHCC, participating Ministries, and Agencies.

The consultation process will be a continuous issue throughout the life of the project and will be used as a means of checks and balances for the proper implementation of the project. The process will employ a technically and culturally appropriate approach, which involves identifying the concerned/affected stakeholders, soliciting their views, and continuously checking if their views are being taken care of as the project implementation progresses.

The views of the project interested and affected persons were fully considered during the Environmental and Social Management Framework (ESMF) preparation and shall continue to form a basis for further design and implementation of the sub-projects throughout the HSDSP AF-(V) project implementation. The current process aims to improve and facilitate decision making and create an atmosphere of understanding that actively involves project-affected people and other stakeholders in a timely manner, and that these groups are provided sufficient opportunity to voice their opinions and concerns that may influence project decisions.

From the 19th to the 27th of August 2020, the consulting team conducted a series of stakeholder consultations in Mashonaland East, Harare, Bulawayo, Matabeleland South, and Matabeleland North Provinces, as part of the process of developing the current ESMF. As explained earlier the consultations took various forms which include:

- One on one interviews,
- Focus group meetings with community groups,
- administration of Questionnaires (Physical and electronic) and
- Zoom Meetings with Key stakeholders

The stakeholders were consulted to solicit their views and concerns as regards the impact of the activities resulting from the implementation of the HSDSP AF-(V) project.

There was more insight during the field visit and consultations of which most of it was used to develop this ESMF. This section will give selected feedback mostly focusing on areas of concern that the project may need to interrogate but not limited to those only.

Figure APP 1 Focus Group Meeting – Sikente Clinic, Tsholotsho

APP 5.3 STAKEHOLDERS' ATTITUDES TOWARD THE PROJECT

All stakeholders were supportive of the project since it is geared to strengthen the Health Delivery System. The primary beneficiaries, ordinary villagers, mothers, and their children will be afforded a chance to access health care services easier and get a reprieve livelihood improvement from improved nutrition. They appreciated the contribution the project will have on improving the social wellbeing of the nation in general. The following is an analysis of the stakeholders' concerns, including table 8-4:

- ***Health benefits:*** **-** The project will benefit people by making Health services more available especially as regards lactating mother, and adolescents, including, their families,
- ***Improve access:*** **-** The project will help improve access to quality Health care facilities as they will access new equipment and motivated staff from performance Based financing scheme,
- ***Strengthen basic health systems:*** **-** The project will help to strengthen basic health systems to position the country to better manage the complex Maternal Health problems and the Malnutrition burden. It will prioritize: (i) improving quality and availability of skilled human resources ranging from CHW to the nursing staff at the health Care Centres, who will now be having strengthened diagnostic and treatment capacities,
- ***Human Resources:*** **-** The project will improve the quality and availability of Health care human resources by promoting the development of a skilled health workforce for disease control across the country.

Table APP 5.3 Analysis of stakeholder Concerns

NO.	PROVINCE	CONCERNS RAISED (Potential social and environmental impacts)	SUGGESTED MITIGATION MEASURES
1.0	Mashonaland East.	**Positive impacts:** • Health for all. • Longevity. • Availability of medicines. • Integrated approach. **Negative impacts:** • Air pollution. • Water pollution. • Social fabric breakdown. • Institutional failure. • Medical shortcomings. • Vehicle shortage. • Incinerator breakdown. • Waste disposal system breakdown. • Accumulation of expired drugs. • Staff shortage. • Infrastructure breakdown. • Water tanks shortage. • Sewer bursts. • Power outages. • PPE shortage.	• Need new incinerators in province. • Rehabilitate the burners. • Waste separation at source. • More bins should be availed. • Bin liners. • Fenced waste holding areas. • Burnt waste should be properly disposed. • Social norms to be maintained. • Minor works to be done in all facilities. • Drugs to be provided. • Dedicated vehicles e.g., ambulances and waste collection trucks. • Vacancy filled. • Packages to be given front line workers. • Training of staff on IPC to be done. • All old plumbing to be replaced. • Water tanks and boreholes to be connected to buildings. • Sewer bursts to be repaired. • Solar power required to augment power. • PPE to be provided.
2.0	Harare. Wilkins. Beatrice. Mbare.	**Positive impacts:** • Teamwork. • Health. **Negative impacts:** • -sewer bursts. • Water shortages. • water loss. • water shortages. • autoclaves broken down. • laundry machines broken down. • incinerators broken down. • waste separation not occurring. • patients not practising social distancing. • dirty wards. • pre-treatment of sewer not done. • old pipes 62 years old. • Seeping of water tanks. • 3rd floor of hospital receives no water. • Scavengers collect waste. • Power outages. • Overcrowding of patients. • Walls dirty. • Staff not trained in IPC. • Laundry machine broken. • Mortuary overflow. • Hospital building /windows broken.	• Borehole drilling. • Sewer repairs. • Pipe repairs. • Tank installation and repair. • Repair of autoclaves. • Repair laundry machine. • Build incinerator. • Repair burners. • Waste separation to be done at source. • Social distancing to be practised. • Wall repainting to be done. • Pre-treatment to be done. • Rehabilitate old water pipes. • Sealing of water tank to be done. • Water tank to be placed on roof of 3rd floor. • Gated fence to be placed around waste holding area. • Solar backup. • Train staff on IPC. • New mortuary to be completed funds permitting. • Replace windowpanes.
3.0	Bulawayo.	**Positive impacts:** • Health. • Longevity. • Economic recovery. **Negative impacts:**	• Complete new mortuary. • Repair burners. • Build new incinerator. • Boreholes. • Repair spill. • Replace manholes.

NO.	PROVINCE	CONCERNS RAISED (Potential social and environmental impacts)	SUGGESTED MITIGATION MEASURES
		• Mortuary overflow. • Air pollution. • Water pollution. • Laboratory spills/ Sewerage spills. • Manhole corrosion. • Waste not collected. • Incinerator waste not disposed. • Water shortage. • Solar panel theft. • Swing doors not in place. • PPE not enough. • Isolation centres too few. • No social distancing in isolation centres. • No dedicated vehicle. • Training of IPC not done. • Gene expert not fully resourced. • Not enough disinfectants.	• Separate waste at source. • More bins. • Bin liners. • Colour coding. • Fence waste area. • Panels be replaced. • Water tanks connected boreholes. • Place swing doors. • Provide enough PPE. • Practice social distancing. • Provide dedicated vehicles for staff transport waste collection and laundry chores. • Cartridges should be bought for gene expert machine.
4.0	Matabeleland South.	• Mortuary door broken. • Windowpanes broken. • Air pollution. • Water pollution/Sewer leakages. • Land degradation. • Fence broken around facilities. • No fence around incinerators and waste holding sites. • PPE shortages. • Walls dirty. • Old pipes need replacing. • Staff not IPC trained. • Staff understaffed. • Broken glass and tape replacement required.	• Replace manholes. • Separate waste at source. • More bins. • Bin liners. • Colour coding. • Fence waste area. • Panels be replaced. • Water tanks connected boreholes. • Place swing doors. • Provide enough PPE. • Practice social distancing. • Provide dedicated vehicles for staff transport waste collection and laundry chores. • Cartridges should be bought for gene expert machine.
5.0	Matabeleland North.	• Longevity. • Availability of medicines. • Integrated approach. • Air pollution. • Water pollution. • Social fabric breakdown. • Institutional failure. • Medical shortcomings. • Vehicle shortage. • Incinerator breakdown. • Waste disposal system breakdown. • Expired drugs accumulating. • Staff shortage. • Infrastructure breakdown. • Water tanks shortage. • Sewer bursts. • Power outages. • PPE shortage.	• Need new incinerators in province. • Rehabilitate the burners. • Waste separation at source. • More bins/ Bin liners should be availed. • Fenced waste holding areas. • Burnt waste should be properly disposed. • Social norms to be maintained. • Minor works to be done in all facilities. • Drugs to be provided. • Dedicated vehicles e.g., ambulances and waste collection trucks. • Vacancy filled. • Packages to be given front line workers. • Training of staff on IPC to be done. • All old plumbing to be replaced. • Water tanks and boreholes to be connected to buildings. • Sewer bursts to be repaired. • Solar power required to augment power. • PPE to be provided.

APP 5.4 PROOF OF PUBLIC CONSULTATION

Three examples of consulted stakeholders have been included as samples. The complete documentation of the engagement process is covered in Volume 2 of this report: "**PROOF OF PUBLIC CONSULTATION"**.

APP 5.4.1 EMA

MINISTRY OF HEALTH AND CHILDCARE

ZIMBABWE HEALTH SECTOR DEVELOPMENT SUPPORT PROJECT

ESMF QUESTIONAIRE

HEALTH FACILITY / ORGANISATION ……ENVIRONMENTAL MANAGEMENT AGENCY

PHYSICAL ADDRESS 685/6 LORRAINE DRIVE, BLUFFHILL, HARARE

NAME OF REPRESENTATIVE DADIRAI KWENDA

PHONE NUMBER 0776 878 428 E –MAIL ADD: dadirai.kwenda@ema.co.zw

The Government of Zimbabwe has received funding for the Zimbabwe Health Sector Development Support Project funded by World Bank-Global Financing Facility under the Result Based financing (RBF) programme through an Additional Financing V. The objective of the programme is to improve coverage and quality of an integrated package of RMNCAH-N services, as well as strengthen COVID-19 response and institutional capacity to manage performance-based contracts consistent with the Recipients' ongoing health initiatives. CORDAID is the Programme Implementing Entity.

Among other things, the project will expand the RBF package of services to cover prioritized RMNCAH-N and other related services to respond to Zimbabwe's burden of disease while also reconfiguring the RBF approach to appropriately respond to the COVID-19 pandemic. Also, in the Additional Financing V project, no major civil works will be undertaken, only very minor sanitation structures (such as septic tanks or pit latrines, ventilated improved pit latrines, composting toilets, or pit latrines with slabs), and the installation of water tanks in selected isolation centres, supplies for handwashing facilities and basic sanitation facilities in critical areas will be supported. Additional activities may include minor improvements to buildings such as painting, rehabilitation, or refurbishment. However, these interventions will have a bearing on the social and environmental dimension, necessitating the preparation of environmental and social safeguards instruments.

1. ***What environmental and social impacts do you foresee during planning, implementation, and operation of the project?***

Planning – inclusion of people across various gender dimensions in project development, improper project siting, inadequate consultation.
Implementation - Deforestation, waste management issues, dust generation from construction activities, health, and safety issues
effluent discharge during operation, foul smell, possibility of underground water pollution if septic tanks are connected to soak ways, improper medical waste handling and disposal, flies if there is poor ventilation.
Social Impact - Public health issues when the toilets fill up, children and livestock falling in the toilets, loss of cultural resources, resistance to use the compost in the case of composting toilets, gender discrimination, violation of labour rights, HIV and sexually transmitted diseases contraction, conflict within community members.

2. ***What mitigation measures would you like to see being put in place to prevent or minimise the impacts you foresee*?**

An Environmental and Social Management Plan for the activities to be undertaken and submitted for monitoring before activities are undertaken. This should include waste management disposal facilities, frequent desludging of septic tanks, adequate PPE, use of blind septic tanks, and waste segregation at source in line with applicable standards.

3. **Other Comments**
   N/A

SIGNED.

SIGNED. ..... INTERVIEWEE ..... INTERVIEWER 31/8/20 DATE

THE WORLD BANK IBRD • IDA

Cordaid

APP 5.4.2 COVID DESIGNATED HOSPITALS/isolation centre

Meeting with Wilkins Hospital

Date: 28 August 2020

Figure…APP 2 Wilkins Waste holding Area

1.0 In Attendance

No.	NAME	ORGANISATION	DESIGNATION	CONTACT No. AND E-MAIL ADDRESS
4.1.1	Andrew Tapera	MoHCC	Admin	0773392220 atapera@yahoo.com
4.1.2	Rhoda Dzawara	MoHCC	Srn	0773286166 rhodadzawie@gmail.com

2.0 Proceedings of the meeting

Introduction

The general overview was given by Ms C Gwayagwaya. The administrator articulated the status quo and showed the existing situation.

Isolation Facility

The surgical ward was turned into an isolation ward. The ward has 40 beds and 2 ICU. the ward has no oxygen in place.

Laboratory

The laboratory is working and is on level 3 clearance.

Waste management

Incinerator

There is segregation of waste at source. Use of black and, yellow bins are done. Since incinerator not working the use of burners in Hartcliffe is done.

Mortuary

The mortuary is in good working order however the body lifter needs repair.

Autoclave

There are no autoclaves working.

Laundry machines

There is no functional laundry machine and outsourcing occurs**.**

Vehicles

There are no dedicated vehicles for workers and waste management, but one vehicle is used to carry waste, laundry and food.

Environmental Impacts

The highlighted impacts include air pollution, water pollution land degradation,

Mitigation measures should include rehabilitation of sewers systems, incinerators, and waste collection facilities. The water reticulation system should also be looked at.

Social Impacts

Social conflicts due to shortages of social services and other key needs, moral decay and breaking of the social fabric.

Mitigation measures to include the repairs of ambulances, supplying of adequate drugs, information dissemination and ensuring that allowances are given to the frontline workers to avoid de-motivation.

APP 5.4.3 Consultations with the NGOs

The following are the NGOs in the Health and Nutrition sector which could be consulted. Due to the pandemic situation, only three NGOs were consulted; and UNICEF, OXFAM and Fencraft investments. Oxfam excused themselves since they don't deal with medical waste, UNICEF has not responded yet and Fencraft gave a detailed response which is attached here below.

NO.	THE NGO COMMUNITY IN HEALTH & NUTRITION	RESPONSE TO QUESTIONAIRE
1	Food and Agriculture Organization (FAO),	
2	World Vision	
3	Care Zimbabwe	
4	Médecins Sans Frontières	
5	HOPE / DAPP Zimbabwe	
6	International Medical Corps (IMC)	
7	The United Nations Children's Fund (UNICEF)	Response awaited
8	World Food Programme (WFP)	
9	Save the Children (SCI)	
10	Action Contre la Faim (ACF)	
11	Cultivating New Frontiers in Agriculture (CNFA) – Amalima Project	
12	Zimbabwe Red Cross Society (ZRCS)	
13	Fencraft Investments Pvt Ltd	Response Attached
14.	OXFAM	Responded and excused themselves since they don't handle any waste.

1.0 SITUATIONAL ANALYSIS OF THE HCWM SYSTEM IN ZIMBABWE

Fencraft's experience in Zimbabwe covers central hospitals, provincial hospitals, district hospitals as well as rural and urban clinics. They found out that the problems of HCWM are systematic across all the healthcare facilities and should be very easy to resolve with a deliberate strategy to change the situation. The lessons that they learnt are applicable to the entire country and include the following:

- The existing legislation does not adequately address issues of HCWM and therefore there is need for developing appropriate legislative tools.
- HCW at the source of generation is not classified according to its type for easy treatment and final disposal.

- Many HCFs do not take due responsibility for the waste they generate and the impact it has on the environment and the public to ensure safe, efficient, sustainable and acceptable methods for collection, storage, transportation, pre-treatment and final disposal both within and outside their premises.
- Local authorities do not have sound managerial approaches for dumpsites and the use of appropriate technologies, which would minimise health risks that result from inadequate management of hazardous health-care waste. Scavenging is allowed to take place at all dumpsites without taking necessary measures to abate it.
- The level of theoretical and practical knowledge among those involved in handling hazardous health-care waste is low.

2.0 FENCRAFT'S INPUT TO THE MAIN CONTENT OF THE PROPOSED NATIONAL HEALTHCARE WASTE MANAGEMENT PLAN

- The National Environmental Health policy and strategies should be blended with necessary statutory instruments governing HCWM to strengthen regulation of HCWM.
- All HCFs should obtain all the basic environmental permits and licenses which will enable them to deal with environmental impacts of HCW including among others the following; air pollution, land degradation/soil pollution, health impacts and water pollution.
- The national HCWM Plan should incorporate a HCWM code of practice or SOP.
- The proposed NHCWMP should integrate HCWM plans into the existing National Expenditure Framework plans
- The proposed NHCWMP should galvanise the development of a culture of compliance to approved HCWM practices in all HCFs that will facilitate behavioural change among health workers.
- Ensure that all HCFs have in place appropriate, reliable and sustainable technologies for hazardous waste collection, storage, transport, pre-treatment, treatment and final disposal.
- Ensure that HCW is segregated at service level and accorded according to colour of the container
- Develop monitoring indicator and reporting on wastegeneration
- The National Health Care Waste Management Plan (NHCWP) being the road map that aims at putting in place a sustainable Health Care Waste Management (HCWM) system in Zimbabwe should also recommend safe, efficient, sustainable, affordable and acceptable methods for the treatment and disposal of health-care waste (HCW), both within and outside health-care facilities.
- Due to inadequate resources health care facilities in Zimbabwe continue to struggle and are forced to implement HCWM systems under adverse circumstances where resources (financial, human and material) are limited, planning is hampered and health facilities resort to using inappropriate methods to manage waste. Against this background, the NHCWMP must specifically allow for HCFs to annually set aside a significant budget for capacity building, procurement, maintenance and repair of equipment so as to ensure that the agenda for HCWM is raised in Zimbabwe. It is envisaged that in order to ensure sustainability of the HCWM system, HCFs will be required to include HCWM financing in their annual actions plans. This should be specifically spelt out in the National Healthcare waste management plan.
- The proposed HCWMP should therefore incorporate the need for each HCF to develop their own contextualised HCWM policies and HCWMP which dovetails and speaks to the NHCWM policy and NHCWMP using the provision of the law. Through the NHCWMP, health care establishments and other institutions that generate HCW will be able to institute more appropriate waste management systems that are safe, effective and compliant with the national laws.

- The proposed NHCWMP should also capture the current Zimbabwean legal provisions and international conventions regarding the management of HCW and compliance with the same.
- The proposed NHCWMP should outline in detail the healthcare waste handling practices that all HCFs in Zimbabwe should religiously follow covering:
  a) The Practice of Waste Segregation
  b) Packaging
  c) Colour coding
  d) Labelling
  e) Storage (Internal and external)
  f) Collection of healthcare waste for treatment
  g) Routing
  h) Transportation methodology of the health care waste to the HCW treatment facility
  i) HCW treatment procedures
  j) Required compliant HCW treatment infrastructure for on-site and off-site HCW treatment
  k) Occupational health and safety process during the handling of HCW from the point of care, treatment to the final disposal of the treated HCW residues.

- The proposed NHCWMP should also provide for the strengthening of institutional capacities for HCWM through the development of structures at all levels of health care starting with the national level, provincial level, district level and individual HCF level to supervise and manage health care waste.
- The need for continuous capacity building in the form of staff training, follow up and refresher courses should also be considered for incorporation in the proposed NHCWMP.
- Technologies for treatment and disposal of HCW should also be clearly spelt out in the proposed NHCWMP.
- The proposed NHCWMP should also consider incorporating a strategy for the implementation, monitoring and evaluation of the NHCWMP where healthcare facilities in Zimbabwe will also be required to set up customized waste management systems based on the most appropriate means of achieving the environmentally safe management of health care waste at a reasonable cost dependent on their level of operation clearly stating the resources needed for successful implementation of the plan of action both human and financial.

APP 5.5 STAKEHOLDER VALIDATION WORKSHOP

A two-day validation workshop for the **HSDSP AF (V) ESMF AND ICWMP** was conducted in Harare on the 7th and 8th of June 2021. The validation workshop was held in order for the Government of Zimbabwe officials, the possible people who will be implementing the ESMF and other affected stakeholders, to assess if the ESMF covers all their concerns adequately. The validation workshop also acted as a by-in process for all the officials to understand and own the document so that implementation will be easy.

The workshop was attended by more than thirty experts from the MoHCC departments: Environmental Health, Nursing Services, Quality, M/E, Communication, Ministry of local government and public works, EMA, CORDAID and the two consultants who prepared the ESMF and the ICWMP.

APP 5.5.1 LIST OF PARTICIPANTS

Table APP 5.2 is the list of the stakeholders who attended the validation workshop.

Table APP 5.2 List of Consulted Stakeholders from Stakeholders Validation Workshop

NAME	ORG/ DEPT/ PROVINCE	DESIGNATION	EMAIL ADDRESS	CONTACT NUMBER
1. VICTOR NYAMANDI	MOHCC HQ	DIRECTOR EH	victornyamande@gmail.com	772809365
2. TEMBA MOYO	PMD MIDLANDS	PEHO	timzamoyo@gmail.com	774028331 713188088
3. EDINGTON D SITHOLE	MOHCC/ ENV/ HQ	EHO	edsithole58@gmail.com	718428119/ 0777551843
4. MUSIWARWA CHIRUME	MOHCC	DIRECTOR QA/9	chirumemusiwarwo@gmail.com	*774954622*
5. CHARLES SIACHIMA	MOHCC HQ	ACTING DD	csiachema@gmail.com	771542087
6. NTANDOKAMLIMU NONDO	EMA	P. O.	ntandonondo@ema.co.zw	772990134
7. ADMIRE DOMBOJENA	HARARE CITY HEALTH	DHPO	dombojena@gmail.com	773264800
8. PAUL MATSVIMBO	MOHCC - MASH EAST	MPMD	pfmatsvimbo@gmail.com	772855029
9. KAMBONDO GEORGE	MOHCC - PMD MASH WEST	DHPO	kambondogeorge@gmail.com	773476905
10. CHIFAMBA PAULOS	MOHCC HQ/ QAQI	QUALITY ASSURANCE OFFICER		
11. RUMBIDZAI CHIMUKANGARA	MOHCC - HQ	HPM	rchimu@gmail.com	773468834
12. DANDA SYDNEY	MOHCC EDC HEAD OFFICE	NVCO	syddanda@gmail.com	772739624
13. MORDESTER MUTIMUKULU	MOHCC - HQ	NURSE ADMIN OFFICER	mordmuti@gmail.com	
14. WELLINGTON MUSAKWA	MOHCC -HQ	PRO	wmusakwa@gmail.com	773922835
15. PAUL CHINAKIDZWA	MOHCC - HQ	D/ DIR-HP	pchinakidzwa@gmail.com	772727046
16. JOYLEEN CHIMONYO	MOHCC - HQ	PRO	mohcccomms@gmail.com	775650647
17. BRIAN D CHAKAWAPANO	CORDAID - MASHWEST	PRBRO	brianchakawapano@gmail.com	7796605511
18. ABIGAIL MUSARA	MOHCC HQ/ ENV/ HQ	WASTE MANAGER	musaraabigail@gmail.com	773621413
19. USHE COSMAS	MOHCC - HQ/ QAQI	DRIVER		772774271
20. CHIPO MAKWEZWA	MOHCC ENV HEALTH SERVICE	PROG ASST	makwezwac@gmail.com	772130609
21. CHIPO S GWAYAGWAYA	CORDAID	CONSULTANT	cgwaya@gmail.com	778086536
22. SIBEKILE MTETWA	CORDAID	CONSULTANT	mikemtetwa@live.com	
23. BLOODWELL TARUME	CORDAID	ENVIRONMENTAL SPECIALIST	bloodwell.tarume@cordaid.org	779623850
24. MUSA M T	CORDAID	PRBFO		
25. DODZO LILIAN	MOHCC - HQ	DIRECTOR-NURSING	dodzolilian@yahoo.com	712831382
26. PAIDAMOYO MAGAYA	CORDAID	COMM SPECIALIST	pai@cordaid,org	782702274
27. K NYATHI	MOHCC - PCU	RRF HEALTH SPECIALIST	kny@cordaid.org	776248128
28. TRISH MUKUNYADZI	CORDAID	RRF URBAN VOUCHER EXPERT	Trish.Mukunyadzi@cordaid.org	773 508354
29. ENDRIS SEID	CORDAID	TEAM LEADER	Endris.Mohammed@cordaid.org	772161805

APP 5.5.2 THE WORKSHOP AGENDA

The following table outlines the agenda for the ESMF and ICWMP Validation Workshop- 7-8 June 2021- Mazowe Hotel:

Table APP 5.3 The Worksho Agenda

Time	**Activity**	**Facilitator**	**Chair/ Rapporteur**
	Day 1		Environmental Health/ Health Promotions
0800-0815	Introductions	All	
0815-0830	Welcome Remarks	MOHCC	
0830-0840	Admin Issues		
0840-0850	Workshop Objectives	MOHCC	
0850-0920	Overview of the HSDSP AF	Cordaid	
0920-0950	Overview of the Safeguards Instruments -ESMF	Consultant	
0950-1000	Introduction group work on ESMF	Cordaid	
1000-1030	**Tea Break**		
1030-1130	Group Work (by Thematic Area in the ESMF Draft document)	All	
1130-1300	Plenary session-Thematic Topics 1-3 (introduction, environmental and social methodology, project baseline information)	Consultant	
1300-1400	**Lunch**		
1400-1430	Plenary session-Thematic Topics 4 (Zimbabwe legal framework and World Bank safeguards policies)		Health Promotions/ Env. Health
1430-1500	Plenary session -thematic topics 5 &6 (Environmental and social impacts of the project; classification, screening, approval and implementation)		
1500-1530	**Tea Break**		
1530-1600	Plenary Session Thematic Topic 7 (Project complaints, conflict and Grievance Redress Mechanisms)		
1600-1630	Plenary session- Thematic Topic 8 (Stakeholder consultation, engagement and disclosure)		
1630-1700	Plenary Session- Thematic Topics 9-11 (Monitoring and supervision, institutional capacity, and implementation budget).		
	Day 2		
0800-0815	**Recap**	**Health Promotions**	**Public Relations/ Env. Health**
	Overview of ICWMP	**Consultants**	
0815-0830	Introduction To Group Work on ICWMP	Cordaid	
0830-1000	Group Work (by Thematic Area)	All	
1000-1030	Tea Break		

1030-1100	Plenary Session- 1. Introduction, project context and components, laws and Policies		
1100-1130	Plenary Session- 2. Health Care Structure, Infection control and waste management		
1130-1200	Plenary Session-3. Emergency preparedness and response		
1200-1230	Plenary Session- 4. Institutional arrangements and capacity building		
1230-1300	Plenary session- 5. Stakeholder consultation		
1300-1400	**Lunch**		
1400-1430	Summary key issues ESMF	Consultants	
1430-1500	Summary key issues ICWMP	Consultants	
1500-1530	**Tea Break**		
1530-1600	Recommendations	MOHCC	
1600-1615	Closing Remarks	MOHCC	

APP 5.5.3 WORKSHOP REPORT

The workshop validated the ESMF on the first day and then the ICWMP on the second day. The Consultant presented the overview of the instrument first and then the participants were divided into four groups each with particular areas to concentrate on as shown in table 1.

Table 1. Areas to concentrate on for group work

GROUP	No.	THEMATIC AREAS	AREAS TO CONCENTARATE ON
Group 1	1	Thematic Topics 1-3 (introduction, environmental and social methodology, project baseline information)	• Potential Risks and Impacts • Implementation arrangements • Analysis of Baseline data • Analysis of Safeguard Policies and Regulations • Project Baseline Information – were baseline issues adequately captured. Are there any gaps
	2	Thematic Topics 4 (Zimbabwe legal framework and World Bank safeguards policies)	• Were all relevant acts and regulations captured • Is the gap analysis adequate
Group 2	3	thematic topics 5 &6 (Environmental and social impacts of the project; classification, screening, approval and implementation)	• Is the social and environmental impact analysis adequate. • Does the ESMP cover all relevant issues • Is the screening process good enough to capture all potential impacts of sub-projects?
Group 3	4	Thematic Topic 7 (Project complaints, conflict and Grievance Redress Mechanisms)	• Is the GRM system adequate to handle all potential conflicts
	5	Thematic Topic 8 (Stakeholder consultation, engagement and disclosure)	• Is the proposed Stakeholder Engagement process suitable for meaningful continuous engagement
Group 4	6	Thematic Topics 9-11 (Monitoring and supervision, institutional capacity, and implementation budget)	• Is the monitoring plan adequate for the intended purpose? • Are the monitoring indicators sufficient? • Is the proposed capacity building sufficient for the ESMF implementation? • Is the proposed budget sufficient for the ESMF implementation?

After the group work each group presented its findings in plenary and was subjected to rigorous discussions to give clear guidance to the consultants on the proposed changes. Also, after each presentation the consultants were requested to present a summary of the outcome of the particular groupwork. The following table outlines the comments that emanated from all the deliberations of the workshop:

The following table lists the comments that came out of the Validation Workshop together with the response to the comments, indicating how and where the comments were incorporated into the ESMF.

Table 2. Workshop Comments and responses on the ESMF

NO.	PAGE/SECTION	WORKSHOP COMMENTS	CONSULTANTS RESPONSE TO COMMENTS
	GROUP 1.		
	Page 7 - section 1.5	add “environmental safety”, on line number 8-9, which talks about "Effective administrative, infection-controls and engineering controls must be put in place...." it could read: "Effective administrative, infection-controls, engineering controls and environmental safety controls must be put in place...."	The phrase “environmental safety”. Has been added.
	Page 8 - Table 1 – 1	division of subsidies? 75% of subsidies going to CHWs	Division of subsidy has been done in the following manner: • Community health worker 25% • Health care staff 25% • Community activities 50%
	Page 9 - 1.5.1 ii -	OHS is it Environmental or Social since what is at risk are people	The source of the risk is environmental, i.e., physical, chemical, or biological hazards thus it is an environmental risk.
	Page 9 - 1.5.2 iii, iv, and v	look the same	Its all-hazardous waste generated from different sources or activities of the project.
	Page 12 – section 1.7	Ministry of Environment, Climate, Tourism and Hospitality Industry.	This has been corrected
	Page 12 – section 1.7	add Local authorities	Local authorities were added.
	Page 16, section 2.2. - Analysis of baseline Data	The group felt that this is adequate at the time of convening	noted
	Page 17, section 2.4 - Analysis of Safeguard Policies and Regulations	The group felt that this is adequate at the time of convening	noted
	From Page 18. Project Baseline information – • Were baseline issues adequately captured • Are there any gaps?	The group felt that nothing is left and all issues are addressed	noted
	Any other comments – on Page 42	The Public Health Act is now 15:17 EMA act is 2027	Corrected accordingly
	Page 42 to 43, Section 4.2	Make clear reference to section 73 and section76 of the national constitution and mention that the activities of the project ultimately feed into the National Development Strategy 1 (2021-2025) and the 2030 National Vision	Clear reference to sections 73 and 76 has been made and the activities of the project linked to the National Development Strategy 1 (2021-2025) and the 2030 National Vision
	GROUP 2		

	Page 79 section 5.2 Environmental risk/Impact analysis 5.2.1 (iii)	Incinerators are not fenced/not functional (well protected which becomes a risk to the public (Each facility should have its own facilities. There is need for people who are trained on operation and maintenance of incinerators.	The risk from incinerators has been included as point (iv) under section 5.2.1
	Page 79 section 5.2.1 (iv)	**Proper segregation of waste and disposal of waste at point of generation can be improved through trainings.** *Please add the information in the mentioned paragraph*	Risk of lack of proper segregation and non-availability of on-site treatment included in point (vi) of 5.2.1
	Page 84 section 5.3 Need for grievance redress mechanism. (3rd paragraph)	GRM -Toll Free Number (2019) should be mentioned always so that people are reminded. Please add the phone number 2019	There is a national covid-19 toll free number which is 2019, however the number can be used for general purposes including raising grievances. This toll-free number has been added as suggested.
	Page 84 section 5.3.1 (iii) Risks to vulnerable groups	Exclusion of disadvantaged groups in consultations. **There is need for representation of vulnerable groups in different structures e.g., HCC, Ward committee, CHWs so that their voices are heard.** *Please add the bolded sentences the way you see fit*	This has been added as point (iv) of section 5.3.1
	Page 85 section 5.3.2 Planning phase (i) Project Timing	**There is need for sensitization meetings in the localities so that communities are aware of what is going on. (Community awareness).** *Please add the bolded part the way you see fit*	This has been added
	Page 85 section 5.3.3 Potential risks of healthcare workers	• Availability, adequacy and poor practices in PPE use should also apply to all care levels, (Central, Provincial, District hospitals and Clinics). • **There is need to strengthen practices through trainings on the rational use of PPE at all levels of care.** • **Health care workers should put on scrubs at clinical settings which should be washed and stored at the facility to protect the public from contamination.** *Please add the bolded parts the way you see fit*	This has been included as point b) of section 5.3.3 (i)
	Page 86 section 5.3.3 (iii) (c) Misinformation in social media networks relate to COVID 19	• **Handling of project and personal information-tracking of media every now and then to correct myth and misconceptions on how to deal with the pandemic.** • **Call centres should be established and well manned and provided with the necessary tools (e.g., tablet/phone dedicated for that).** *-Please add the bolded sentences the way you see fit* *-The word publicising was spelt wrongly.*	This has been added. Spelling mistake was corrected
	Page 89 section 5.5 Environmental social management plans (ESMPs) Last paragraph	Table 5-3 below Please delete the word 'below'	The word "below" has been deleted.
	GROUP 3		
	Page 128, Section 7.2	Suggestion: the boxes should be opened daily	This has been included.
	Page 130, Section 8.2	• Delete the introductory statement as it is a repetition	The statement was deleted.
	Page 130, Section 8.2.1	Rephrase the objectives	the objectives have been Rephrased accordingly

	Page 131, Table 8-1	Delete last two rows	Last two rows were deleted.
	Page 131, Paragraph below table 8-1	Delete whole paragraph. Delete. Repetition. This has been said earlier	whole paragraph was deleted
	Page 131, Table 8-2	• Delete Referral Hospitals and add Central hospitals and General hospitals.	• Referral Hospitals was deleted and Central hospitals and General hospitals added.
		• Remove COVID designated Hospitals and replace with Infectious Diseases Hospitals	• This has not been effected since the project will be supporting the COVID-19 Designated Hospitals and not all general Infectious diseases hospitals.
		• Include Headman and Village Heads as stakeholders under Ministry of local Government	• Headmen, Village Heads were added
		• Include Ministry of Women affairs	• Ministry of Women Affairs was added
	Page 132, Section 8.2.3	Delete paragraphs 2, 3 and 4 as they are a repetition	The paragraphs have been removed/deleted **but the said repetition is not there.**
		• Paragraph 5 …delete …by the project Environmental Specialist.	Phrase was deleted
		rephrase the last two paragraphs to "Engagement under normal circumstances and in pandemics is basically the same. The slight difference is that with COVID-19, gatherings are not encouraged."	The paragraph has been reviewed and the emphasis of limited gatherings, meetings and interviews has been kept.
	Page 132, Section 8.2.3.1	• Delete "….All things being equal…"	Phrase deleted
	Page 133, Table 8-3	• Replace "One on One Meetings" with "Key informant Meetings" • Replace "Formal Meetings" with Advocacy Meetings • Replace "Focus Group Meetings" with "FGDs"	All edits in table 8-3 were effected.
	Page 134, Section 8.2.3.2	• Delete whole section and replace it with a statement "Appropriate engagement techniques should be adopted depending on the outbreak"	The paragraphs have been deleted. The phrase "appropriate engagement techniques should be adopted depending on the outbreak." Has been included and then the possible appropriate techniques have been elaborated.
	Page 134, Section 8.3	• rephrase paragraph 2 to "…..achieved when the community actively participate from problem identification, preparedness, response/action, and after action activities"	The statement was rephrased accordingly.
	Page 134, Section 8.3	• rephrase these three paragraphs as they are winding, and long. Replace with "MoHCC alone cannot address disease prevention and control. It has to actively engage other stakeholders hence the need for a multisectoral approach"	The paragraphs have been rephrased.
	Page 134, section 9.1 paragraph 2 and throughout the document	On the name of the Ministry of Environment, Climate, Tourism and Hospitality Industry (MECTHI). Change this throughout the document including the abbreviations to reflect the suggested changes. For example, in the list of abbreviations, figure 1-1, section 9.1 paragraph 2. Also check name for the Ministry of Local Government, Public works and National Housing (the correct name should read, Ministry of Local Government and Public Works)	• the name of the Ministry of Environment, Climate, Tourism and Hospitality Industry (MECTHI) has been changed throughout the document • Ministry of Local Government and Public Works has also been corrected throughout the document
	GROUP 4.		
	page 138 to 140, Table 9-1,	**noise**-no comment	Noted and No action

		health-replace the acronym AIDS with HIV and also add an indicator to speak on WASH	• the acronym AIDS was replaced with HIV, under the positive indicators. • an indicator to speaking on WASH has been added
		waste management- • remove statement reading "*no accumulation of wastes* and to • add under positive indicator use of designated waste management site. • under positive indicator list the classes of hazardous waste and • explain on regularity under frequency	• statement reading "*no accumulation of wastes" was removed.* • Use of designated waste management site being used for hazardous waste disposal Added. • Hazardous Waste classified into four **categories** denoting environmentally safe (blue), low **hazard** (green), medium **hazard** (yellow) and high environmental **hazard** (red) • Regular, weekly monitoring of hazardous construction waste and hazardous medical waste
		Air pollution- add an indicator on PPE	Indicator for PPE added "Appropriate PPE for protection from dust always provided. (See IWCMP for details)"
		• **water resources -** correct grammar second bullet under method of monitoring • under positive indicator rephrase the statement to read water resources should be managed to carter for environmental concerns. • the indicators to be SMART like the last one on complaints. • it's good to merge the indicators on page 139 and 143 to plan.	• Grammar corrected. • under positive indicator rephrase the statement to read water resources should be managed to carter for environmental concerns. • All indicators made SMART
	page 138 to 140, Table 9-1,, column 5	on frequency there is need to remove ''regularly" and be more specific as agreed and indicate whether the frequency is daily, weekly, monthly or annually whichever is applicable.	''regularly" has been replaced by more specific monitoring regimes.
	page 142 to 143, Tale 9-3,	8.0 under occupational health and safety.... second bullet to unpack what is meant by number of local workers with health problems.	This has been elaborated to mean "Number of non-health care staff at project sites with health problems"
		Gender to read Gender main streaming	Corrected accordingly
		point 10.0 to list the vulnerable groups,	(vulnerable persons have been listed as people with chronic conditions/disabled, poor people, migrants, the elderly and, disadvantaged sub-groups of women, Indigenous Peoples (IPs).)
		3rd bullet under 11.0 to ratio of man statement to be put under gender	Bullet moved to gender mainstreaming row.

APP 5.5.4 IMPACT OF THE VALIDATION WORKSHOP

The validation workshop had a profound impact on the ESMF and its implementation in the following manner:

- The contributions from the Participants sharpened the ESMF instrument to make it more specific and to be aligned to situations on the ground.
- The Consultant took advantage of the experience and technical knowledge of the participants to make certain sections of the ESMF clearer.
- The Ministry of Health Officials became enlightened about the ESMF, the contents of the document and its requirements in terms of implementation
- Many officials expressed that before the workshop it was a complicated document, but after the workshop they now understood it.
- The workshop assisted in a buy-in process for the Ministry to own the document and start identifying with it.

APPENDIX 6 TEMPLATES FOR ENVIRONMENTAL AND SOCIAL MANAGEMENT PLAN

Three main sub-project types have been identified, that is i) Construction and refurbishments sub-projects, ii) RBF implementation sub-projects and iii) COVID-19 emergency response sub-projects. The following is an outline of the Template ESMPs for these types of sub-projects which the beneficiaries can adapt to their specific situations:

APP 6.1 CONSTRUCTION AND REFURBISHMENTS

The construction and refurbishment activities include the following:

- Refurbishments, rehabilitation, or minor civil works at health care facilities
- Refurbishments of COVID 19 Isolation centres
- Installation of water tanks
- Installation of basic sanitation (flush/pour flush to piped sewer system, septic tanks, pit latrines, ventilated improved pit latrines, composting toilets or pit latrines with slabs).
- installation of water tanks in selected isolation centres and supplies for handwashing facilities
- installation of basic sanitation (flush/pour flush to piped sewer system, septic tanks, pit latrines, ventilated improved pit latrines, composting toilets or pit latrines with slabs).
-

Table APP 6.1 ESMP Template for Minor Construction and Refurbishment Sub-projects.

No.	POTENTIAL NEGATIVE IMPACTS	MITIGATING MEASURE	RESPONSIBILITY
1.	Physical Restrictions to existing footprint of institutions for planning of refurbishments	Consider the following safety measures: • Availability of fire extinguishers and/or fire alarm systems and appropriate storage areas for chemicals. • Investigate presence of hazardous and flammable materials to reduce risks. • Investigate presence of asbestos Containing Materials (ACM) • Investigate presence of Obsolete Chemicals, drugs, equipment, etc. • Local inhabitants and workers should be informed of all safety measures. • Plan the Signals and the necessary signage to be placed close to potential areas of danger.	• Health Facility • PIE Environmental Specialist • Contractor
2.	Soil and land degradation Point source contamination from spilled paints, diesel, lubricants etc. around workshop areas	• Appropriate containment measures for all operational areas and proper disposal of used lubricants. • Proper design and layout of structures avoiding too steep a gradient. • Land levelling. • Design of terraces on hillside minimizing surface erosion hazard. • Contain accidental discharges of oils etc. from Equipment.	• PIE Environmental Specialist • Contractor • Local EMA Officer
3.	Generation of solid construction waste	• Seek guidance of local environmental officers to identify acceptable disposal sites.	• PIE Environmental Specialist

No.	POTENTIAL NEGATIVE IMPACTS	MITIGATING MEASURE	RESPONSIBILITY
		• Contractors should undertake waste segregation at source to separate hazardous from non-hazardous waste. (e.g., asbestos removed from the buildings prior to main demolition/refurbishment works) • Temporary storage of waste must not block traffic. • All waste to be properly disposed at suitable disposal sites • Toxic waste properly and securely stored before disposal • Toxic waste disposed of properly at landfill sites.	• Contractor • Local EMA Officer
4.	Accidental release of potentially hazardous solvents, acidic and alkaline materials.	• Maintenance of storage and disposal areas to prevent accidental release • provide spill mitigation equipment.	• PIE Environmental Specialist • Contractor • Local EMA Officer
5.	Pollution of Ambient Air: Air quality will be impacted by emissions from vehicles, building equipment and released particulate matters (dust).	• Institute dust control measures • Demolish small sections of the hospital cut away from patients • use of suitable clothing and protective equipment • Contractors should use dust screens or nets in windows, doorways, and ventilators in rooms where demolition or other dusty construction activities are occurring • All workers to receive appropriate PPE	• PIE Environmental Specialist • Contractor • Local EMA Officer
6.	Pollution of Ambient Water: Water quality will be impacted by wastewater discharges from the refurbishment activities including onsite sewage and rainwater run-off.	• Prevent run-off washing any pollutants or waste piles away into public streams • Contractor to employ proper sanitary facilities • Pollution from lubricants and other wastes to be avoided. • Seek guidance of local environmental officers to identify acceptable disposal sites.	• PIE Environmental Specialist • Contractor • Local EMA Officer
7.	Occupational health effects on workers due to fugitive dust, materials handling, noise, or other process operations. Accidents occur at higher-than-normal frequency because of level of knowledge and skill.	Development of a Safety and Health Program in the facility to address the hazards to worker health and safety and procedures for employee protection, including any or all the following: • site control and monitoring • training • medical surveillance • decontamination procedures • emergency response • regular safety meetings • sanitation at permanent and temporary facilities • All safety precautions must be enforced • Provide PPE [25]to all workers	• PIE Environmental Specialist • Contractor • MoHCC
8.	Threat to historic, cultural, or aesthetic features.	• Siting of extensions to prevent loss.	• PIE Environmental Specialist

[25] PPE for waste handlers and practitioners must include face masks and eye protection (especially for cleaning of hazardous spills), and respirators (for spills or waste involving toxic dust or incinerator residue).

No.	POTENTIAL NEGATIVE IMPACTS	MITIGATING MEASURE	RESPONSIBILITY
		• Salvage or protection of cultural sites or artifacts.	• Contractor • Local EMA Officer • NMMZ
9.	Temporary Visual Intrusions: Rehabilitation and upgrading of Health Care facilities will change the characteristics of the area and leave marred landscapes.	• Contractor should ensure minimum footprint of construction activities and provide decent accommodation for workers. • All altered landscapes (Sand pits, borrow pits, brick moulding sites etc) should be rehabilitated by the contractor.	• PIE Environmental Specialist • Contractor • Health Facility
10.	Noise: Noise and vibration caused by machines, site vehicles, pneumatic drills etc	• Contractor to avoid old equipment. • Heavy duty equipment to be minimized. • Noisy operations to be limited to certain times. • Noise levels to be limited to within acceptable levels.	• PIE Environmental Specialist • Contractor • Local EMA Officer • Health Facility
11.	Disruption of Utilities Service: demolitions and refurbishment activities may cause temporary disruptions of utility services	• Contractor to bring own generators to avoid interrupting facility power. • Contractor to map out all utility lines well before embarking on civil works. • Any service disruption must be reconnected as soon as possible • Alternative means of providing the service must also be used.	• PIE Environmental Specialist • Contractor • Health Facility
12.	Temporary disruption of Health Care services: Since facilities under renovation will not be closed, they will experience shortages of working space.	• Plan pre-construction activities early to identify suitable rooms or adjoining buildings into which to relocate patients with minimal inconvenience. • Refurbishment should be in phases so that the whole facility is not disrupted at once	• PIE Environmental Specialist • Contractor • Health Facility
13.	Impacts of construction activities on patients, staff and other stakeholders: Refurbishment work undertaken in the same buildings having patients and staff has potential to cause injuries to the occupants.	• Contractors should cordon off areas under construction • Ensure good housekeeping and clean operations always immediately removing rubble strewn outside construction areas. • Construction workers should limit verbal noise or other forms of noise during the renovation works inside the buildings. • Contractors should use screens or nets to avoid flying debris and dust.	• PIE Environmental Specialist • Contractor • Health Facility

APP 6.2 RBF implementation

RBF implementation will involve the following:

- Increased Health care Service Provision
- Expand the RBF package from RMNCAH-N, TB, and HIV to include NCDs such as hypertension at primary level and diabetes at secondary care level.
- support the piloting of an Expanded Supply Side Community (ESSC) RBF in line with the Community Health Strategy in four rural districts
- support community mobilization and health promotion by community health workers (CHW).
- scale up the RBF to additional municipal health facilities with a possibility of expanding the package to include family planning for poor pregnant urban women, etc.
- scaling-up the Urban Voucher (UV) scheme to more health facilities and including vitamin A supplementation for 18-59-month-old children of UV target mothers, etc.
- finance equipment and TA to strengthen the referral system across the four levels of health care.
- scaling up the RMNCAH-N focused 5s[26]-CQI interventions
- equipping and strengthening functional skills laboratories[27] for Emergency Obstetric and Neonatal Care and Family Planning in central, provincial and district hospitals

Table APP 6.2 ESMP Template for RBF implementation Sub-Projects.

No.	POTENTIAL NEGATIVE IMPACTS	MITIGATING MEASURE	RESPONSIBILITY

1.	Increased generation of medical and infectious waste (infecting people and contaminating water, air and soil, etc.) from enhanced and scaled up health services provisions and strengthened laboratory services.	• Enforce implementation of the ICWMP in all institutions:
		  ○ Segregation at source
		  ○ Using colour coded bins
		  ○ Timeous collection of waste to treatment points
		• Sufficient treatment of the waste.
		• Make waste handling materials readily available at all institutions
		• Incinerators and other treatment facilities should always be in working condition.
		• Alternative treatment methods should always be at hand in case of breakdowns
		• Control of Health care activities to minimize environmental problems.
		• Training caregivers on proper handling of home-based health care waste.
			• PIE Environmental Specialist
			• Health facility
			• Local Environmental Officer.

2.	• Waste generated during installation of new equipment • Increased generation of medical waste, including obsolete drugs	• Proper waste management practices should be maintained including final disposition at authorized sites	• PIE Environmental Specialist • Health Facility

[26] The 5S (Sort, Set in Order, Shine, Standardize, Sustain) System aims to improve management organization and efficiency in workplaces.

[27] Skill laboratories are specific practical skill training facilities that offer the possibility of training clinical procedures in a safe environment prior to real life application. Equipping the skills labs will involve procurement of a package of equipment whose installation does not involve any works.

No.	POTENTIAL NEGATIVE IMPACTS	MITIGATING MEASURE	RESPONSIBILITY
	• Improvements in Waste management not meeting the increment in clinical waste generation from the improved Health Delivery system.	• Medical waste to be properly disposed-of in accordance with the project Infection Control and Waste Management Plan. • Clinical Waste management must be continuously improved, and the requirements of the Zimbabwe **Infection Control and Waste Management Plan (ICWMP) prepared for this project**, adhered to.	• Local Environmental Officer.
3.	Potential Risks of healthcare workers	• All safety precautions must be enforced • Provide appropriate PPE to all workers	• PIE Environmental Specialist • Health Facility
4.	inappropriate capacity building initiatives in place	• Conduct training needs assessment, and upgrade, and update knowledge, and skills of health personnel.	• MoHCC • PIE • Health Facility
5.	WASH infrastructure development impacts and risks include: o Operations during construction period, impacts such as dust, noise, nuisance to community, OHS risks to workers, waste generation o for normal operations, pollution to water bodies, health risks to patients and staff if proper hygiene and disinfection practices not followed	• WASH infrastructure development should continue to be developed. • Contractors to put in place such measures as dust suppression, use of low noise machinery, cutting off sections of the facility at a time, etc. to minimize any impacts on patients and use of proper PPE. • All workers to receive appropriate PPE	• Contractors, • Health Facility • PIE Environmental Specialist
6.	• Stress and fatigue of Health workers (especially nurses), cleaners, ambulance drivers and caterers, who may be asked to work overtime to respond to the COVID-19 pandemic. • Health workers, a big proportion who are female (and who may also bear additional responsibilities in terms of child and eldercare), may face mental health issues or burnout as result of an outbreak.	• All workers must be provided with security of medical care, ensuring they can access free medical care if they contract COVID-19. • Ensure that all staff, including cleaners, caterers, part-time workers, etc. have access to the required Personnel Protection Equipment (PPE) – including gloves, gowns, masks, and eye protection if exposed to patients with COVID-19, • Health care workers must be actively supported by their employers and commended for their work, as well as offered psychological, emotional, or mental support if possible. This may mean ensuring health workers have regular breaks and proper food throughout the day. • All workers involved in upgrading facilities, health workers, cleaners, etc., must be reassured that they will continue to get paid if they need to self-isolate if they are showing symptoms of COVID-19 infection.	• MoHCC • PIE • Health Facility
7.	OHS issues of Health workers, cleaners or workers involved in upgrades.	Train all workers on special occupational health and safety guidelines and practices to follow during the COVID-19 crisis in line with WB & WHO guidelines.	• Health Facility • PIE Environmental Specialist
8.	Increase interactions with communities, gender-based violence, and community conflicts due to continuous interaction with local communities.	• Implement relevant measures to mitigate potential impacts between the staff, CHW and community members i.e., operating two GRMs, one for staff and other for project beneficiaries to report on issues that concerns them. • Ensure that community workers including communities and vulnerable groups would also be made aware on protocols to adhere to during community interactions such as practicing proper hygiene, masking, other safety precautions and social distancing measures.	• Health Facility • PIE Environmental Specialist

APP 6.3 COVID EMERGENCY RESPONSE

COVID-19 emergency response, will involve the following activities:

- Increased Labouratory testing for COVID - 19 diagnosis (procurement of Polymerase Chain Reaction (PCR) based laboratory test cartridges),
- General COVID - 19 response operations (Motor cycles and Fuel),
- PPE kits and IPC-related goods for quarantined cases, rapid response teams who conduct contact tracing, and health personnel working in isolation health care facilities and hospitals,
- medical waste management and disposal systems in selected permanent and temporary isolation healthcare facilities as needed,
- provide medical care to COVID-19 patients through provision of medical supplies like oxygen concentrators and medical equipment like ICU sets (beds, ventilators) for selected treatment centres,
- improve referral of COVID-19 affected individuals to treatment centres through procurement of fully kitted ambulances and
- provide food and basic supplies including linen and possibly menstrual hygiene kits for temporary isolation centres and treatment facilities,
- Supply of Materials at Isolation Centres including:
    - menstrual health kits,
    - masks,
    - Gene Xpert Cartridges for PCR test to diagnose COVID-19,
    - IPC self-care kits for quarantined cases,
    - PPE and goods for health personnel involved in patient case management,
    - medicines and medical supplies, diagnostic reagents including kits for public health facilities.

Table APP 6.2 ESMP Template for COVID Emergency Response Sub-Projects.

No.	POTENTIAL NEGATIVE IMPACTS	MITIGATING MEASURE	RESPONSIBILITY
1.	Increased generation of medical and infectious waste (infecting people and contaminating water, air, and soil, etc.) from enhanced health services provisions, supplies of consumable Materials from the project, etc.	• Enforce implementation of the ICWMP in all institutions: o Development of Waste Management Plan o Segregation at source o Using colour coded bins o Timeous collection of waste to treatment points • Sufficient treatment of the waste. • Make waste handling materials readily available at all institutions • Incinerators and other treatment facilities should always be in working condition. • Alternative treatment methods should always be at hand in case of breakdowns • Control of Health care activities to minimize environmental problems.	• Health Facility • PIE Environmental Specialist
2.	Potential Risks of healthcare workers from Contracting COVID-19 at work.	• All safety precautions must be enforced • Provide PPE to all workers	• MoHCC • Health Facility

No.	POTENTIAL NEGATIVE IMPACTS	MITIGATING MEASURE	RESPONSIBILITY
			• PIE Environmental Specialist
3.	Water pollution from discharge of liquid effluents • Health care facility: TSS; temperature; pH • Materials storage piles runoff: TSS; pH • Most Health care packaging produces solid waste.	• Manage laboratory effluents properly and not discharge toxins down the drain. • Laboratory analysis of liquid effluent (including cooling water runoff from waste piles) in O/G, TDS, TSS, BOD, COD, and in-situ temperature monitoring. • Seek guidance of local environmental officers to identify acceptable disposal sites.	• Health Facility • PIE Environmental Specialist • Local EMA Officer
4.	Accidental release of potentially hazardous solvents, acidic and alkaline materials.	• Maintenance of storage and disposal areas to prevent accidental release • provide spill mitigation equipment.	• Health Facility • PIE Environmental Specialist • Local EMA Officer.
5.	OHS issues of health workers, cleaners or workers involved in upgrades, due to fugitive dust, materials handling, noise, or other process operations. Accidents occur at higher-than-normal frequency because of level of knowledge and skill.	• Train all workers on special occupational health and safety guidelines and practices to follow during the COVID-19 crisis in line with WB & WHO guidelines. • Development of a Safety and Health Program in the facility designed to identify, evaluate, and control safety and health hazards at a specific level of detail to address the hazards to worker health and safety and procedures for employee protection, including any or all of the following: o site characterization and analysis o site control o training o medical surveillance o monitoring o information programs o decontamination procedures o emergency response o illumination o regular safety meetings.	• MoHCC • Health Facility • PIE
6.	• Stress and fatigue of health workers (especially nurses), cleaners, ambulance drivers and caterers, who may be asked to work overtime to respond to the COVID-19 pandemic. • Health workers, a big proportion who are female (and who may also bear additional responsibilities in terms of child and eldercare), may face mental health issues or burnout as result of an outbreak.	• All workers must be provided with security of medical care, ensuring they can access free medical care if they contract COVID-19. • Ensure that all staff, including cleaners, caterers, part-time workers, etc. have access to the required Personnel Protection Equipment (PPE) – including gloves, gowns, masks, and eye protection if exposed to patients with COVID-19, • Health care workers must be actively supported by their employers and commended for their work, as well as offered psychological, emotional, or mental support if possible. This may mean ensuring health workers have regular breaks and proper food throughout the day. • All workers involved in upgrading facilities, health workers, cleaners, etc., must be reassured that they will continue to get paid if they need to self-isolate if they are showing symptoms of COVID-19 infection.	• MoHCC • Health Facility • PIE
7.	**Infections**: There may be possible risk of COVID-19 virus infections at the treatment facilities to Health Care workers and general workers involved in activities such as testing for COVID-19, transportation of samples to testing facilities, delivery and storage of goods,	• Health facilities should establish and apply Standard Precautions including: o Hand Hygiene (HH). o Respiratory hygiene/cough etiquette. o Use of personal protective equipment (PPE). o handling of patient care equipment, and soiled linen.	• Healthcare facilities, • PIE

No.	POTENTIAL NEGATIVE IMPACTS	MITIGATING MEASURE	RESPONSIBILITY
	including samples, pharmaceuticals, cleaning, waste collection, etc.	○ Environmental cleaning. ○ Prevention of needle-stick/sharp injuries. ○ Appropriate Health Care Waste Management.	
8.	Poor sanitation and improper management of wastewater related to COVID-19 diagnosis and treatment services transmit diseases to communities and pollute environment.	• Health facilities shall ensure the provision of safe water, sanitation, and hygienic conditions, which is essential to protecting human health during COVID-19 outbreak. • Enhanced cleaning arrangements should be put in place, to include regular and deep cleaning using disinfectant of food and drink facilities, toilets/showers, communal areas, including door handles, floors and all surfaces that are touched regularly. • Ensure cleaning staff always have adequate PPE.	• Healthcare facilities, • PIU
9.	• Hazardous materials used and generated during the provision of COVID-19 diagnosis, care, and treatment services • Hazardous chemicals in the hospitals and health care centres are limited to small volumes of laboratory reagents, chemicals, solvents, medicinal gases etc.	• The hospitals and laboratories should have hazardous material management procedures and procedures for reporting of incidents as outlined in the project ICWMP for further details especially on management and storage of reagents. • Hazardous materials should be handled in accordance with the accepted practices. Only trained personnel should handle the materials and precautions taken when handling materials by using required protection equipment such as ventilation hoods and personal protective equipment.	• Healthcare facilities, • PIE
10.	• **Vulnerable people excluded**: planning and design of measures to screen people for COVID-19 and information materials developed could exclude the most vulnerable, including the poor, elderly, indigenous peoples, people living with a disability and households headed by single women, who are also less likely to have access or be active on social media. • Vulnerable groups and people in the rural areas are at heightened risk if they contract COVID-19 due to their remoteness in accessing treatment (though their remoteness may protect them from contracting the virus). Their location may also make the diagnosing and treatment of the virus more difficult.	• Develop programme packages geared for the most vulnerable (the poor, elderly, women single heads of household, IPs, those with disabilities). • hazardous material management procedures having clear communication materials about (i) how to avoid contracting COVID-19 (good hygiene measures); (ii) symptoms of COVID-19; (iii) what to do if suspect have COVID-19. • Ensure that testing and treatment centres are disability inclusive. • Provide specific advice for people - usually women - who care for children, the elderly and other vulnerable groups in quarantine, and who may not be able to avoid close contact.	• MoHCC • GoZ • PIE
11.	• Focus on COVID-19 may redirect staff and resources at health facilities and negatively impact other areas, such as maternal health check-ups, vaccinations for children and treatment of chronic diseases. • People, in particular women with young children, pregnant women, the elderly, those with disabilities, chronic illness, and other vulnerable populations, may be fearful of going to the hospital/health centre for fear of contracting the virus. • children missing out on needed vaccinations, women not seeking support during pregnancy, etc.	• Hospitals and other health facilities must ensure they still have adequate staff to deal with ongoing medical needs. • Communication materials must stress that these normal services are still being provided, and explain measures taken in health centres to avoid COVID-19 risks This may include radio messages, Facebook, loudspeaker announcements, signage in hospitals, etc.	• Healthcare facilities, • PIE

APPENDIX 7 TEMPLATES FOR ENVIRONMENTAL AND SOCIAL MONITORING PLANS

Three possible sub-project types have been identified; i) construction and refurbishment sub-projects, ii) RBF implementation sub-projects, iii) COVID-19 emergency response sub-projects and the following are the template ESMPs for them:

Table APP 7.1 Environmental Monitoring Template for construction and refurbishment.

No.	ISSUE	*METHOD OF MONITORING*	AREAS OF CONCERN	POSITIVE INDICATOR	FREQUENCY	RESPONSIBLE AUTHORITIES
1.	Noise	Noise monitoring should be carried out on an ad-hoc basis by the Environmental Monitor or the PIE to establish noise levels in the work areas. The relevant noise level standards are in the General EHS.	• Noise Levels	• Noise levels at the nearest sensitive receiver would be kept to a minimum so as not to disturb the piece of the patients. • Level of noise complying with the work time (7am-6pm)	Quarterly and ongoing as project is implemented.	• PIE • MoHCC • EIA Department of EMA
2.	Health	PIE must ensure that education and awareness campaigns are implemented. The Ministry of Health should carry out awareness campaigns on Hospital Acquired diseases, water-borne diseases, etc and carry out vector control methods such as regular spraying of potential breeding sites (ponds) at facilities. PIE must mainstream HIV/AIDS and COVID-19 issues into the project implementation programme.	• Public health • Ensure that stagnant water is sprayed to destroy mosquito larvae. • Waste management at Sub-project sites. • Disease outbreak due to concentration of people at the Sub-project sites. • Disease outbreak due to dust and water pollution.	Reduction in number of cases of such diseases as, AIDS/STD related diseases recorded at hospital and medical clinic Reduction in number of diseases such as malaria and cholera	Quarterly and ongoing as project is implemented	• PIE • MoHCC • RDCs • Local Leadership
3.	Archaeology	This should concentrate on chance finds. Provision should be made to allow archaeologists to be present on site during any excavation periods if they so wish. The PIE should inspect all excavations, and where archaeological remains are found work must stop until the PIE has been given the all clear to proceed by the NMMZ. The PIE should contact the National Museums and Monuments of Zimbabwe (NMMZ) in	• Archaeological Findings	Archaeological remains not excavated, disturbed or destroyed.	• Quarterly and ongoing as project is implemented • Room for chance finds	• NMMZ • RDCs • MoHCC • PIE

No.	ISSUE	*METHOD OF MONITORING*	AREAS OF CONCERN	POSITIVE INDICATOR	FREQUENCY	RESPONSIBLE AUTHORITIES
		the event of a significant archaeological find.				
4.	Air Pollution	Observations should be made on the level of dust generated during the renovation and rehabilitation activities by the Environmental Monitor or PIE. Dampening should be carried out if levels are unacceptable.	• Levels of dust emissions	• Deposition of dust on surfaces should decrease with increased dampening • Level of pollution vs national and WB standard • Number of speed control ramps with appropriate road signs in case of roads	Quarterly	• EMA • MoHCC • PIE • RDCs
5.	Water resources	• Every institution that will be supported with a water tank must have its water source tested and monitored at least once a year.	• Surface water quality • Ground Water Quality • Potable water quality •	• Pollution of drinking water sources monitored/detected early and remedial measures taken on time • Water bodies meant for drinking complying with the national/WB standards (pH, temperature, visual observations (presence of litter), etc.	Water quality tests for drinking water provided by the project. Boreholes.-.quarterly Surface Water - Monthly Depending on size of plant.	• MoHCC • PIE • Min of Water/ZINWA • EIA Department
6.	Complaints	The PIE should inspect the record of complaints made by local residents, to be kept by the beneficiaries, and should check that action is taken quickly and that the number of complaints do not rise significantly. The GRM should be employed.	• Complaints	Speed with which PIE resolves cases, Conforming with the stipulations of 3 working days for priority 1 and 3 working weeks for priority 2.	Quarterly	• PIE • MoHCC • RDCs • EIA Department

Table APP 7.2 Environmental Monitoring Template for RBF implementation.

No.	ISSUE	*METHOD OF MONITORING*	AREAS OF CONCERN	POSITIVE INDICATOR	FREQUENCY	RESPONSIBLE AUTHORITIES
1.	Health	PIE must ensure that education and awareness campaigns are implemented. The Ministry of Health should carry out awareness campaigns on Hospital Acquired diseases, water-borne diseases, etc and carry out vector control methods such as regular spraying of potential breeding sites (ponds) at facilities. PIE must mainstream HIV/AIDS and COVID-19 issues into the project implementation programme.	• Public health • Ensure that stagnant water is sprayed to destroy mosquito larvae. • Waste management at Sub-project sites. • Disease outbreak due to concentration of people at the Sub-project sites. • Disease outbreak due to dust and water pollution.	• Reduction in number of cases of such diseases as, AIDS/STD related diseases recorded at hospital and medical clinic • Reduction in number of diseases such as malaria and cholera	• quarterly and ongoing as project is implemented	• PIE • MoHCC • RDCs • Local Leadership
2.	Medical Waste Management	• The PIE Environmental Specialist must ensure that all Health Facilities are aware of the developed ICWMP and start implementing it. • All Health Facilities must make sure their waste treatment facilities are operating well or that the waste is transported to the nearest facility with a functional Incinerator.	• Institution of the three-bin system. • Segregation of waste at source. • Proper transportation of the segregated waste. • Conditions of waste treatment facilities.	• Number of facilities implementing ICWMP requirements. • Number of Incinerators and other treatment facilities working properly. • Number of HCW trained in handling Home Based Health Care Waste • Number of specific areas for waste disposal in appropriate formal dumping sites. • -Number of human resources employed in waste management	• quarterly and ongoing as the Health Care Facilities are operating.	• PIE • MoHCC Environmental Health Department • Health Facility • Local EMA Officer
3.	Wash Issues	• PIE will ensure that the Installation of basic sanitation (flush/pour flush to piped sewer system, septic tanks, pit latrines, ventilated improved pit latrines, composting toilets or pit latrines with slabs) is done.	• Sanitary facilities • Supply of running water	• Number of new Sanitary infrastructure installed (latrines, septic tanks, flash toilets, etc). • Number of sanitary facilities refurbished	• Continuous	• PIE • MoHCC Environmental Health Dept • Health Facility • Local EMA Officer

No.	ISSUE	*METHOD OF MONITORING*	AREAS OF CONCERN	POSITIVE INDICATOR	FREQUENCY	RESPONSIBLE AUTHORITIES
		• PIE will ensure that installation of water tanks in selected isolation centres and supplies for handwashing facilities is done		• Number of WASH programmes conducted		
4.	OHS issues of Health workers	• The PIE will make sure that all workers are trained on special occupational health and safety guidelines and practices to follow during the COVID-19 crisis in line with WB & WHO guidelines.	• OHS issues • Personal Hygiene for staff • Protective measures for staff.	• Number of staff trained in special COVID-19 occupational health and safety guidelines and practices • Availability of suitable PPE for all staff • Number of local workers with health problems • Number of accidents caused by or associated with project activities and reported	quarterly	• PIE • MoHCC - Environmental Health Dept. • Health Facility • Ministry of Labour
5.	Complaints	The PIE should inspect the record of complaints made by local residents, to be kept by the beneficiaries, and should check that action is taken quickly and that the number of complaints do not rise significantly. The GRM should be employed.	• Complaints	Number of Cases resolved within stipulated time frame of 3 working days for priority 1 and 3 working weeks for priority 2.	quarterly	• PIE • MoHCC • RDCs • EIA Department

Table APP 7.2 Environmental Monitoring Template for COVID Emergency Response.

No.	ISSUE	*METHOD OF MONITORING*	AREAS OF CONCERN	POSITIVE INDICATOR	FREQUENCY	RESPONSIBLE AUTHORITIES
1.	Health	• PIE must ensure that MoHCC should carry out awareness campaigns on Hospital Acquired diseases, water-borne diseases, etc • PIE must mainstream HIV/AIDS and COVID-19 issues into the project implementation programme.	• Public health • Waste management at Sub-project sites. • Disease outbreak due to concentration of people at the Sub-project sites. • Disease outbreak due to dust and water pollution.	Reduction in number of cases of such diseases as, AIDS/STD related diseases recorded at hospital and medical clinic Reduction in number of diseases such as malaria and cholera	quarterly and ongoing as project is implemented	• PIE • MoHCC • RDCs • Local Leadership
2.	Medical Waste and Hazardous materials Management	• The PIE Environmental Specialist must ensure that all Health Facilities are aware of the developed ICWMP and start implementing it. • All Health Facilities must make sure their waste treatment facilities are operating well or that the waste is transported to the nearest facility with a functional Incinerator.	• Hazardous materials used and generated during the provision of COVID-19 diagnosis, care, and treatment services • Hazardous Laboratory reagents such as formaldehyde, at Health care centres •	• Number of facilities implementing ICWMP requirements. • Number of Incinerators and other treatment facilities working properly. • Number of HCW trained in handling Home Based Health Care Waste. • Availability of hazardous material management procedures and procedures for reporting of incidents.	• Quarterly and ongoing as the Health Care Facilities are operating.	• PIE • MoHCC - Environmental Health Dept. • Health Facility • Local EMA Officer
3.	**Exclusion of Vulnerable people**	• PIE will check and make sure that vulnerable groups are being catered for in each Health facility by checking the numbers being served • PIE will follow-up in areas known to have IPs to make sure they are catered for.	• The poor, elderly, indigenous peoples, and people living with a disability with no access to social media. • Vulnerable people in remote areas.	• Number of programme packages geared to reach out to the vulnerable. • Availability of Clear Communication materials targeting the vulnerable. • testing and treatment centres being disability inclusive	• quarterly and ongoing as the Health Care Facilities are operating	• PIE • MoHCC - Environmental Health Dept. • Health Facility •
4.	Staff Contracting COVID-19 at work	• PIE will make sure that there is continuous regular testing of all staff involved in COVID diagnosis and treatment. • Records of these tests should be shared with PIE for its assessments.	• Provision of appropriate and adequate PPE for all staff including VHWs. • Knowledge of Safety precautions by workers	• Safety precautions being enforced • Number of PPEs available	• continuous and quarterly testing	• PIE • MoHCC • Health Facility

No.	ISSUE	*METHOD OF MONITORING*	AREAS OF CONCERN	POSITIVE INDICATOR	FREQUENCY	RESPONSIBLE AUTHORITIES
5.	Water Pollution	• The PIE Environmental Specialist together with the Environmental Health department of MoHCC will do continuous inspections of facilities to check if there any discharges of effluents into the environment. • PIE will ensure that Environmental Health department of MoHCC is continuously monitoring the drugs and chemicals storage facilities.	• Discharge of poor-quality effluents into the environment • Waste storage poor and getting washed away • Accidental release of hazardous solvents from laboratories	• Level of Management at Laboratories • Quality Monitoring of water bodies close to facility • Level of maintenance of chemical storage areas • Availability of spill mitigation equipment.	• continuous and quarterly	• PIE Environmental Specialist. • MoHCC - Environmental Health Dept. • Health Facility
6.	OHS issues of Health workers	• The PIE will make sure that all workers are trained on special occupational health and safety guidelines and practices to follow during the COVID-19 crisis in line with WB & WHO guidelines.	• OHS issues • Personal Hygiene for staff • Protective measures for staff.	• Number of staff trained in special COVID-19 occupational health and safety guidelines and practices • Availability of suitable PPE for all staff	quarterly	• PIE • MoHCC - Environmental Health Dept. • Health Facility • Ministry of Labour
7.	Sanitation	• PIE Environmental Specialist to continuously inspect the sanitary facilities of all the project funded isolation centres and Health Facilities.	• Poor sanitary conditions at Isolation centres • Improper management of wastewater related to COVID-19 diagnosis and treatment services.	• Provision of safe water, sanitation, and hygienic conditions. • Availability of enhanced cleaning arrangements, including deep cleaning. • Availability of proper PPE for cleaning staff	• quarterly	• PIE • MoHCC - Environmental Health Dept. • Health Facility
8.	Complaints	The PIE should inspect the record of complaints made by residents, to be kept by the beneficiaries, and should check that action is taken quickly and that the number of complaints does not rise significantly. The GRM should be employed.	• Complaints	Number of Cases resolved within stipulated time frame of 3 working days for priority 1 and 3 working weeks for priority 2.	quarterly	• PIE Environmental Specialist • PIE Communications Specialist. • MoHCC • EIA Department.

APPENDIX 8 ARCHAEOLOGICAL CHANCE FINDS PROCEDURE

ZIMBABWE

ARCHAEOLOGICAL CHANCE FINDS PROCEDURE

FOR

THE ZIMBABWE HEALTH SECTOR DEVELOPMENT SUPPORT PROJECT

(HSDSP)

1.0 INTRODUCTION

The purpose of this document is to address the possibility of archaeological deposits, finds and features becoming exposed during earthmoving and ground altering activities associated with the HSDSP AF-(V) and to provide procedures to follow in the event of a chance archaeological find.

The objectives of these procedures are to identify and promote the preservation and recording of any archaeological material that may be discovered and notify the relevant Rural District Council (RDC), the Environmental Management Agency (EMA) and the National Museums and Monuments of Zimbabwe (NMMZ) to resolve any archaeological issue that may arise (NMMZ, 2001).

2.0 ARCHAEOLOGICAL CHANCE FINDS PROCEDURE

During the project induction meeting/training, all contractors/construction teams will be made aware of the need to be on the lookout for objects of archaeological interest as they carry out their refurbishments/ minor civil works (excavation) activities. For example, the sanitary facilities may require excavation.

Generally, the following procedure is to be executed if archaeological material is discovered:

- Stop all construction activity in the vicinity of the find/feature/site immediately,
- Delineate the discovered find/ feature/ site immediately,
- Record the find location, and make sure all remains are left in place,
- Secure the area to prevent any damage or loss of removable objects,
- Contact, inform and notify the RDC, EMA and NMMZ authorities immediately,
- The Authorities so notified will avail an archaeologist,
- The archaeologist will assess record and photograph the find/feature/ site,
- The archaeologist will undertake the inspection process in accordance with all project health and safety protocols under direction of the RDC Health and Safety Officer,

- In consultation with EMA, NMMZ and MoHCC authorities, the Archaeologist will determine the appropriate course of action to take,
- **Finds retrieval strategy:** All investigation of archaeological soils will be undertaken by hand, all finds, osteological remains and samples will be kept and submitted to the National Museum as required. If any artefacts need to be conserved, the relevant licence (Licence to Alter) will be sought from the NMMZ,
- An on-site office and finds storage area will be provided, allowing storage of any artefacts or other archaeological material recovered during the monitoring process,
- In the case of human remains, in addition to the above, the Local Leadership will be contacted and the guidelines for the treatment of human remains will be adhered to. If skeletal remains are identified, an osteoarchaeologist will be available to examine the remains,
- **Conservation:** A conservator should be made available to the project, if required,
- The on-site archaeologist will complete a report on the findings as part of the licensing agreement in place with the NMMZ,
- Once authorisation has been given by the responsible statutory authorities, the client will be informed when works can resume.

APPENDIX 9 HSDSP AF-(V) GRIEVANCE REDRESS MECHANISM

1.0 INTRODUCTION

The grievance redress mechanism (GRM) is a system by which queries or clarifications about the project will be responded to, problems with implementation will be resolved, and complaints and grievances will be addressed efficiently and effectively.

The communication specialist will be the focal person for monitoring implementation of this GRM. She will be supported by MoHCC head health promotion department and public relation unit. At province and district level, she will be supported by the health promotion officers.

2.0 PURPOSE OF THE GRM

The GRM will serve a purpose to:

- be responsive to the needs of beneficiaries and to address and resolve their grievances.
- serve as a conduit for soliciting inquiries, inviting suggestions, and increasing community participation.
- collect information that can be used to improve operational performance.
- enhance the project's legitimacy among stakeholders.
- promote transparency and accountability.
- deter fraud and corruption and mitigate project risks.

3.0 STRUCTURE OF THE GRM

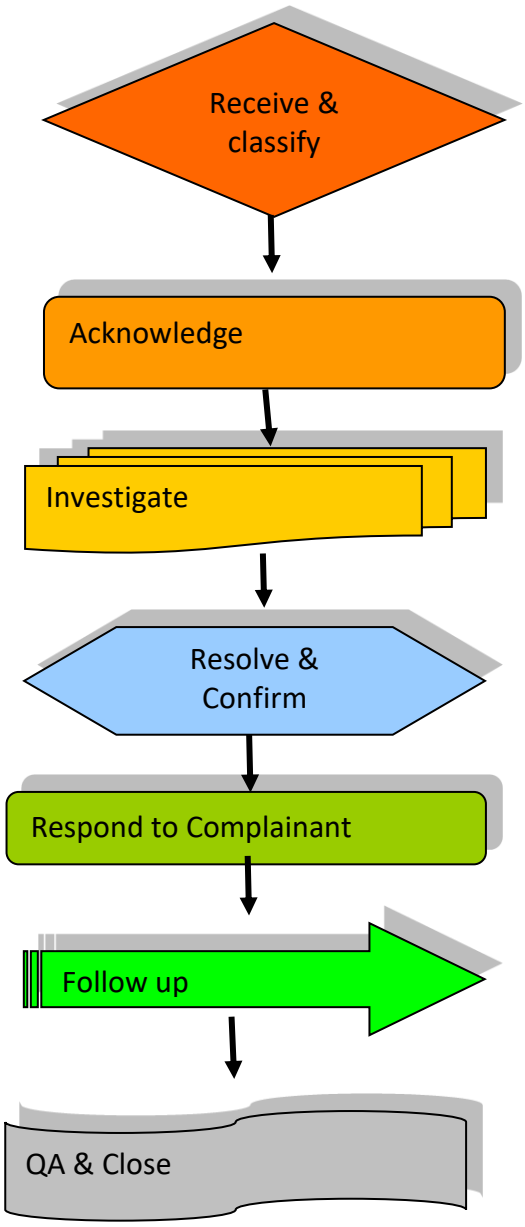
The GRM consists of a small number of components:

- The access point for impacted/concerned people
- Grievance log
- Assessment stage
- Acknowledgement stage
- Response
- Room for appeal
- Resolution

The components are summarized in the process flow diagram below:

Process Overview

The following key steps must be followed for all complaints received by HSDSP AF-(V) PIE staff:



The requirements for each of these steps is detailed below

The facility level Administrator is responsible for receiving, recording, and classifying grievances. **He/she e**nsures that all potential issues are captured and classified for escalation, review and action as required.

- The access point for impacted/concerned patients or people will be situated as close to the project affected person (PAP) as possible. This will be established at each Health Facility, CORDAID Office and MoHCC District, Provincial and Head offices so that it will be credible and accessible:
  - At the various Health Facilities phone numbers will be posted and notices written indicating the process to be taken when aggrieved.
  - At the various Health Facilities there will be a Suggestion Boxes (Also used as grievances boxes) situated in the reception area, where anonymous reports can be deposited. The community: the CBO and HCC will oversee the keys to the boxes.
  - At all Ministry of Health and Child Care (MoHCC) Offices there will be Suggestion boxes situated in the reception area, where anonymous reports can be deposited
  - At the various Health Facilities and MoHCC Offices there will be a designated officer who receives, classify, and log all grievances.
  - At all sub-project and CORDAID offices there will be a grievance box and a designated CORDAID staff will be responsible for receiving the Grievances, classifying, and logging them.

The main issues for the access point includes the following:

- Uptake channels should include some or all the following:
  - phone hotline,
  - email,
  - mail,
  - SMS,
  - webpage,
  - Grievances Box
  - anonymous complaints
  - or face-to-face.
- The uptake channels will be publicized and advertised via local media and the implementing agency.
- Verbal complaints should be recorded by staff for them to be considered.
- Many complaints may be resolved ‘on the spot’ and informally by project staff but should also be logged in order to (i) encourage responsiveness; and (ii) ensure that repeated or low-level grievances are being noted in the system.
- The GRM should have the ability to handle anonymous complaints.

Typically, the complainant will be provided with a receipt and 'roadmap' telling him/her how the complaint process works and when to expect further information.

- Any complaint, issue, or negative stakeholder interaction (whether this is formally logged by the complainant or not), must be logged and classified for action.

- All these complaints must be formally logged using the standard forms.

- <u>All complaints must be prioritised as follows:</u>

  - **Priority 1 – urgent**, potential high health and high business impact. **This requires a response to the Complainant within three (3) working days.**

    - This should be used (sparingly) for major health issues where the complaint may have disastrous impacts on either human, the environment or HSDSP AF-(V) itself.
    - Also, this could be used in a situation where the complainant may be able to influence or make public statements that would impact upon the HSDSP AF-(V) reputation.

  ✓ **Priority 2, - non-urgent**, lower health, environmental and social impact. This requires a response to the complainant within 2 working weeks.

    - This should be used for most complaints with individual stakeholders, as this allows a reasonable time to collect information and produce a balanced response.

- Discretion and flexibility should be exercised in prioritizing all complaints

- The staff member logging the complaint should review the complaint and its priority with the Health Facility Manager/Sister in Charge, before proceeding to the next step.

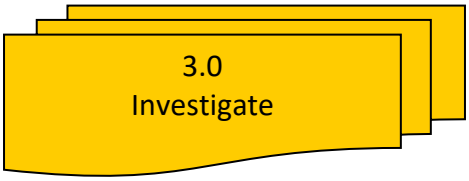
- Health Facility Managers/Sister in Charge will decide on the appropriate person(s) to carry out subsequent steps, including the investigation.

- **All Priority 1 complaints must be escalated immediately to the Health Facility Manager**.

2.0 Acknowledge

Summary
The Administrator will ensure that every complaint receives a formal written acknowledgement, containing an expectation of when they will receive a response, and the person dealing with it.

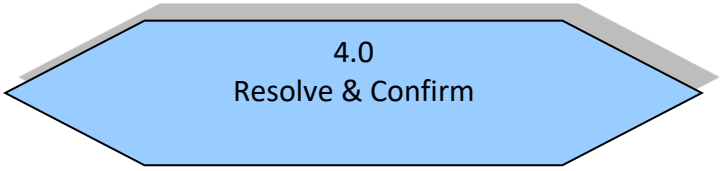
- All complaints, regardless of priority, should receive a pro forma acknowledgement sent out on the day of receipt.



Summary
The assigned member of staff follows up all aspects of the complaint, both internal and external, to ensure that the key facts are identified and clarified.

- The priority of the complaint will drive the timescale for completion (3 days for urgent or 2 weeks for non-urgent).

- All areas of interaction and communication should be established (who, what, where, when, why etc.) and documented where possible.



Summary
The Administrator ensures that the final resolution is clear and fair. He/she also confirms the proposed action and resolution with Facility Manager/Sister in Charge.

- The Administrator ensures that the proposed resolution meets corporate guidelines and does not prejudice HSDSP AF-(V) PIE in any unnecessary legal or financial manner.

- The Administrator documents the proposed action and discusses and agrees with the Facility Manager/Sister in Charge.

- The Administrator Discusses and reviews the solution from both the corporate and complainant viewpoint to ensure fairness and clarity.

- The review should include recognition and documentation of any underlying issues that have contributed to the complaint and recommendations for actions to prevent further occurrence.

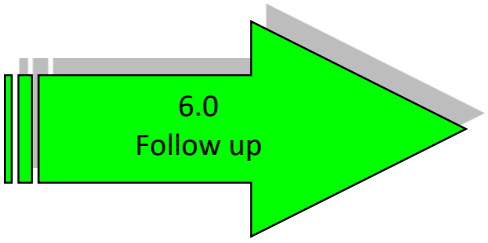
- This should then be reviewed as part of the bi-monthly quality assurance reviews.

5
Respond to Complainant

Summary
The Administrator provides the complainant with the resolution within the timescales promised.

- The details of the findings and proposed resolution should be clearly explained (in written or verbal form as appropriate) to the complainant- within the agreed timescales.

- If this cannot be done on time the complainant should be contacted by telephone to request further time.



Summary
The Administrator ensures that complaints are followed up to confirm that the complainants are satisfied with the response given.

- All Priority 1 complaints and 95% of priority 2 complaints must be followed up within a reasonable timescale.

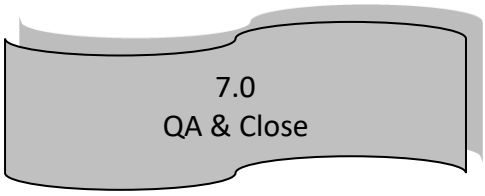
- This will be carried out by the Health Facility Administration team / Health Facility Manager's office.

- The follow-up should identify the following

  - Is the complainant satisfied with the response?

  - Did they feel that their complaint was properly and fairly handled?

- Any negative responses to these questions should be referred to Health Facility Managers for action and direct follow up with the complainant.



Summary
The Administrator must ensure that the facility as a whole is aware of the complaints and any underlying issues. Plan actions to remove these and prevent future recurrence.

He/she then submits a monthly summary incident report to the HSDSP AF-(V) PIE

- All complaints should be reviewed monthly as part of the quality assurance review meetings.
- Any complaints where action can be taken to avoid recurrence must be acted upon and raised with the appropriate managers/teams across the Facility
- A monthly summary incident report is submitted to CORDAID for record keeping and consolidation.

APPENDIX 10 EXPECTED LABORATORY SAFETY FEATURES

Laboratories are encouraged to complete this checklist, using it as a self-audit to help ensure that personnel are proactively addressing concerns about chemical hazards and potential health exposures.

FACILITY_____ROOM #s
_____

PRINCIPAL INVESTIGATOR (PI)_____PI PHONE #
_____

PERSON COMPLETING CHECKLIST
_____

DATE OF LAST PLAN REVISION
_____

No.	CHECKLIST ISSUE	APPRAISAL		SIGNIFICANCE			*POTENTIAL MITIGATION MEASURES*
		Yes	No	Low	medium	high	
1.0	**Experiment Planning, Sops Checklist.**						
	Is an approval required before conducting an experiment?						
1.1	Are chemical experiments thoroughly researched before they are applied?						
1.2	Are the resources used for planning experiments and bench-top operations readily available?						
2.0	**Training Checklist.**						
2.1	Do laboratory personnel receive specific laboratory safety instruction for the activities they are involved with?						
2.2	Have all laboratory staff obtained formal hazardous waste/material training from a recognized accreditation body?						
3.0	**Chemical Inventory, Storage, Labeling Checklist.**						
3.1	Is the chemical inventory kept completed, up to date, and available for inspection?						
	Are chemical reagents segregated by compatibility/reactivity?						
	Are hazardous liquids stored in secondary containment?						
	Are all chemicals and solutions properly labeled?						
4.0	**Hazardous Waste Checklist**						

No.	CHECKLIST ISSUE	APPRAISAL		SIGNIFICANCE			*POTENTIAL MITIGATION MEASURES*
		Yes	No	Low	medium	high	
4.1	is hazardous waste being properly collected and managed?						
4.2	Is the hazardous waste inspection log being checked weekly?						
4.3	are old, unwanted or expired chemicals are promptly submitted for proper disposal?						
5.0	**Chemical Hazard Information checklist**						
5.1	Are hard copies of Material Safety Data Sheets (MSDS) and other chemical hazard information located where its accessible to all staff?						
5.2	Is there a readily accessible computer/printer that all staff can use to internet access any additional chemical hazard resources and MSDS?						
5.3	Are all staff made aware of useful web links?						
6.0	**Ventilation checklist**						
6.1	Are there sufficient, operational chemical fume hood(s), located in the laboratories?						
6.2	Are the fume hoods working properly?						
6.3	Is there a routine of maintaining the fume hoods?						
6.4	Are all hazardous chemicals used inside the fume hood(s)?						
6.5	If not sure whether or not a particular chemical must be used in a hood rather than on the bench-top, is there a way we ask or look up toxicity and other information?						
7.0	**Personal Protective Equipment (PPE) Checklist.**						
7.1	Are laboratory staff supplied with the following PPE: gloves, goggles, aprons, lab coats, face shields and other PPE?						
7.2	Is information about which PPE is suitable for different chemicals readily available?						
7.3	Is there a “work-related health” contact person at the laboratory?						
8.0	**Emergency Preparedness Checklist**						
8.1	Are there emergency eyewashes at the Laboratory?						
8.2	Are there emergency showers at the Laboratory?						
8.3	is there someone responsible for flushing the eyewashes each week?						

No.	CHECKLIST ISSUE	APPRAISAL		SIGNIFICANCE			*POTENTIAL MITIGATION MEASURES*
		Yes	No	Low	medium	high	
8.4	Are there emergency contingency plans, strategically posted around the laboratories?						
8.5	Are means of communication readily accessible, e.g., telephones?						
8.6	Is there emergency spill equipment at the laboratories?						
8.7	Are the nearest fire alarm pull stations conveniently located						
8.9	Are there fire extinguishers in the laboratories						
8.10	Is there a protocol for dealing with an accidental exposure to a hazardous chemical						

APPENDIX 11 ENVIRONMENTAL AND SOCIAL CHECKLIST.

ZIMBABWE

Environmental & Social Checklist

Name of Sub-project Representative:……

Sub-project Name: ……..

Sub-project Address: ……..

……..

Name of Extension Team Representative……..

Address: ……..

……..

		Appraisal		Significance			*Potential Mitigation Measures*
		Yes	No	Low	Medium	High	
1.0	Environmental and Social Checklist						

	Will the project generate the following negative impacts						
1.1	Loss of trees/vegetation						
1.2	Soil erosion/siltation in the area						
1.3	Pollution to land- e.g., from diesel, oils						
1.4	Dust emissions						
1.5	Solid and liquid wastes e.g., open defecation						
1.6	Spread of HIV/Aids and other STI						
1.7	Borrow pits and pools of stagnant water						
1.8	Rubble/heaps of excavated soils						
1.9	Spread of water borne diseases e.g., Malaria						
1.10	Contamination from health care waste handling.						
1.11	Nuisance from smell or noise						
1.12	Reduced water quality and quantity						
1.13	Incidence of flooding						
1.14	Health hazards to workers and communities						
1.15	Removal of native trees						
1.16	Production of asbestos wastes or asbestos Containing Materials (ACM).						
2.0	**Resettlement Checklist**						
	Will the project generate the following negative social and economic impacts?						
2.1	Loss of land by households						
2.2	Loss of properties –houses, structures						
2.3	Loss of trees by households						
2.4	Loss of crops by people						

2.5	Loss of access to river/forests/grazing area						
2.6	Loss of cultural site, graveyard land						
2.7	Conflicts over use of local water resources						
2.8	Disruption of important pathways, roads						
2.9	Loss communal facilities –churches						
3.0	**Water Resources Checklist:**						**DATE**
3.1	When was the water source last tested for potability						
3.2	Was the water quality acceptable						

Consultation (comments from beneficiaries)

Endorsement by Environmental District Officer
Name
Signature: Date

APPENDIX 12 CONSIDERATIONS FOR WORKING WITH ASBESTOS MATERIALS

A. Evaluation of alternatives

1. Determine if the project could include the installation, replacement, maintenance, or demolition of:
   - Roofing, siding, ducts, or wallboard
   - Thermal insulation on pipes, boilers, and ducts
   - Plaster or fireproofing
   - Resilient flooring materials
   - Other potentially asbestos-containing materials

2. If the use of asbestos-containing materials (ACM) has been anticipated for new construction or renovation, provide information about alternative non-asbestos materials and their availability. For new construction, determine the expected difference for the entire project—on initial and operating costs, employment, quality, expected service life, and other factors—using alternatives to ACM (including consideration of the need for imported raw materials).

3. In many cases, it can be presumed that ACM are part of the existing infrastructure that must be disturbed. If there is a need to analyse samples of existing material to see if it contains asbestos, provide information on how and where that can be arranged.

4. Once the presence of ACM in the existing infrastructure has been presumed or confirmed and their disturbance is shown to be unavoidable, incorporate the following requirements in tenders for construction work in compliance with applicable laws and regulations.

B. Understanding the regulatory framework

1. Review the host country laws and regulations and the international obligations it may have entered (e.g., ILO, Basel conventions) for controlling worker and environmental exposure to asbestos in construction work and waste disposal where ACM are present. Determine how the qualifications of contractors and workers who maintain and remove ACM are established, measured, and enforced.

2. Determine whether licensing and permitting of the work by authorities is required.

3. Review how removed ACM are to be disposed of to minimize the potential for pollution, scavenging, and reuse.

4. Incorporate the following requirements in tenders involving removal, repair, and disposal of ACM. 16

C. Considerations and possible operational requirements related to works involving asbestos

1. **Contractor qualification**
   - Require that contractors demonstrate having experience and capability to observe international good practice standards with asbestos, including training of workers and supervisors, possession of (or means of access to) adequate equipment and supplies for the scope of envisioned works, and a record of compliance with regulations on previous work.

2. **Related to the technical requirements for the works**
   - Require that the removal, repair, and disposal of ACM shall be carried out in a way that minimizes worker and community asbestos exposure and require the selected contractor to develop and submit a plan, subject to the engineer's acceptance, before doing so.

- Describe the work in detail in plans and specifications prepared for the specific site and project, including but not limited to the following:
  - Containment of interior areas where removal will occur in a negative pressure enclosure,
  - Protection of walls, floors, and other surfaces with plastic sheeting,
  - Construction of decontamination facilities for workers and equipment,
  - Removing the ACM using wet methods, and promptly placing the material in impermeable containers,
  - Final clean-up with special vacuums and dismantling of the enclosure and decontamination facilities,
  - Disposal of the removed ACM and contaminated materials in an approved landfill,
  - Inspection and air monitoring as the work progresses, as well as final air sampling for clearance, by an entity independent of the contractor removing the ACM.

- Other requirements for specific types of ACM, configurations and characteristics of buildings or facilities, and other factors affecting the work shall be enumerated in the plans and specifications. Applicable regulations and consensus standards shall be specifically enumerated.

3. **Related to the contract clauses**
   - Require that the selected contractor provide adequate protection to its personnel handling asbestos, including respirators and disposable clothing.

   - Require that the selected contractor notifies the relevant authorities of the removal and disposal according to applicable regulations as indicated in the technical requirements and cooperates fully with representatives of the relevant agency during all inspections and inquiries.

4. **Related to training and capacity building**
   - Determine whether specialist industrial hygiene expertise should be hired to assure that local contractors learn about and apply proper protective measures in work with ACM in existing structures.

Originator: World Bank, Operations Policy and Country Services

D. Guidance for prevention, minimization, and control of impacts from ACM.

- Avoiding the use of asbestos containing materials (ACM) in renovation activities.
- Undertaking an asbestos/hazardous products audit prior to/at the beginning of the refurbishment.
- If asbestos is located on the project site, mark clearly as hazardous material.
- When possible, the asbestos will be appropriately contained and sealed to minimize exposure
- The asbestos prior to removal (if removal is necessary) will be treated with a wetting agent to minimize asbestos dust
- Use of specially trained personnel to identify and selectively remove potentially hazardous materials (ACMs) in building elements prior to dismantling or demolition,

- Repair or removal and disposal of existing ACM in buildings should only be performed by specially trained personnel, following, internationally recognized procedures. (WB, 2007)
- If asbestos material is be stored temporarily, the wastes should be securely enclosed inside closed containments and marked appropriately.
- Managing the treatment and disposal of ACMs according to Sections 1.5 and 1.6 on Hazardous Materials and Hazardous Waste Management, respectively.
- Transporting ACM in leak-tight containers to a secure landfill operated in a manner that precludes air and water contamination that could result from ruptured containers. (WB, 2007)

The removed asbestos will not be reused.