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Project Information Document (PID)

Appraisal Stage | Date Prepared/Updated: 05-May-2021 | Report No: PIDISDSA31849

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Project Name	Parent Project ID (if any)
Lesotho	P170278	Lesotho Nutrition and Health System Strengthening Project	
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
AFRICA EAST	20-May-2020	02-Jun-2021	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	Kingdom of Lesotho	Ministry of Health	

Proposed Development Objective(s)

The objective is to increase the utilization and quality of key nutrition and health services and improve selected nutrition behaviors known to reduce stunting.

Components

Community-Based Health and Nutrition Services
District level health system strengthening
Strengthen Government Stewardship, Project Management, and M&E
Contingency Emergency Response Component

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	26.40
Total Financing	26.40
of which IBRD/IDA	22.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	22.00

IDA Credit	22.00
Non-World Bank Group Financing	
Trust Funds	4.40
Scaling up Nutrition	4.40

Environmental and Social Risk Classification

Moderate

Decision

The review did authorize the team to appraise and negotiate

Other Decision (as needed)

B. Context

Country Context

1. **Lesotho is a small, landlocked, lower-middle-income country with a population of 2.1 million in 2017 and a per capita gross national income of US$1,280 (in current US$).**[1] Lesotho generates income mainly through agriculture, exports of textiles, water, and diamonds. Paradoxically, the country is by and large food deficient due to frequent climate shocks, that is, recurrent droughts, dry spells, and floods, especially in rural areas.

2. **Lesotho's economic challenges will be worsened by the pandemic.** Since the 2017 recession, growth is yet to recover averaging only 1.4 percent over the last 2 years (2018 and 2019). Lesotho is facing a tough fiscal outlook as revenues and exports will be further curtailed by the unfolding COVID-19 crisis. Being enclaved by South Africa, Lesotho's economic and social development is closely linked with its much larger neighbor through revenue transfers from the Southern African Custom Union (SACU). A sharp decline in SACU revenues and high current account deficits are expected and will require substantial fiscal adjustment to restore macroeconomic stability. Government revenue is expected to fall from 53.5 percent to 50.6 percent of GDP in FY2020/21, while expenditure is expected to increase from a budgeted 41.6 percent of GDP to 52.9 percent in the same period largely due to measures to mitigate the impact of COVID-19. A financing gap is estimated at US$129 million or 6.8 percent of GDP for the FY2020/21 (Apr 2020 to Mar 2021). Investments are expected to sharply decline as a result of the lockdown, putting pressure on the private sector. Businesses will face liquidity constraints and may be unable to meet their obligations to employees, suppliers, and financial institutions. Overall, a recession is expected in 2020, with projected GDP growth of -5.3 percent.

3. In addition, between April and December 2018, the Government accumulated LSL 1.1 billion (equivalent to US$78 million) in public expenditure arrears. The 2020/21 budget aims at fiscal

[1] World Bank National Accounts Data.

consolidation, including through adjustments to the wage bill, greater efficiency in social sector spending to ensure better outcomes, and the introduction of a levy on tobacco and alcohol along with an increase in value added tax.[2]Fiscal space will be further constrained , as tax revenues are likely to fall due to lower economic activity and health and social protection spending rise in response to the immediate crisis.

4. **Lesotho faces high levels of poverty and inequality.** While, poverty has declined the pace has been slow, and even slower in rural areas. The official national poverty rate fell about 7 percentage points over a 15-year period from 2002 to 2017, falling from 56.6 to 49.7 percent. With an international US$1.90/day (in 2011 PPP terms) poverty rate of 27.8 percent in 2017, poverty is relatively high for a lower middle-income country. Progress in reducing poverty has been much slower in rural areas, and as such poverty remains concentrated in rural and mountainous areas. With a Gini coefficient of 44.6, Lesotho is now the least unequal country among its neighbors but remains one of the 20 percent most unequal countries in the world. Differences in educational achievement during childhood are the most important contributor to unequal opportunities.

5. **Lesotho's Human Capital Index is lower than what would be predicted for its income level. Although h**uman capital levels have improved since 2015, they are constrained by poor education and health outcomes, especially among the poor and rural populations. A score of 0.40 on the Human Capital Index (HCI) means that a child in Lesotho will only be 40 percent as productive as a child who had access to complete education and full health. Life expectancy is 50 years and under-five mortality is 98 per 1,000 live births; both these levels represent a worsening compared to the late 1990s. Malnutrition is an acute problem, with a high stunting (low height for age) prevalence, widespread micronutrient deficiencies in children and adolescents, and high rates of overweight/obesity among women and children.[3] Only 41 percent of children of relevant age complete lower secondary school, and enrollment in secondary school is 33.4 percent. There were twice as many girls attending upper secondary school than boys of the same age. The Government's Second National Development Strategic Plan (NSDP II) for 2018/19–2022/23 aims to improve health and nutrition outcomes, enhance education and skills development, and address food and nutrition security.

6. **The COVID-19 pandemic is posing an additional challenge to Lesotho.** Its population is considered to be at high risk and vulnerable to the COVID-19 pandemic[4]. Lesotho, like neighboring South Africa and Eswatini, is experiencing an important second COVID-19 wave, which accelerated from the end of December 2020. 114 deaths were recorded in January 2021 alone (compared to a total of 51 between July-December 2020). The surge in cases is predominantly due to the holiday period, with gatherings and many Basotho migrant workers returning home from South Africa, with likely spread of the new virus variant which is highly transmissible. The Government of Lesotho has acted swiftly to implement some mitigation measures to stem the rise in the number of cases including imposing a hard lockdown including closure of national borders. As of April 1, 2021[5], Lesotho has reported 10,706 confirmed COVID-19 cases and 315 deaths, an exponential increase in comparison to November 2020 data. Meanwhile, South Africa has reported 1,548,157 confirmed cases of COVID-19 and 52,846 deaths as of March 31, 2021. A quarter of Lesotho's adult population is HIV-positive, with women being disproportionately affected. Among those

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[2] International Monetary Fund (IMF): Kingdom of Lesotho: 2019 Article IV Consultation. April 2019.

[3] Food and Nutrition Coordinating Office (FNCO). 2019. *Lesotho Food and Nutrition Strategy and Costed Action Plan 2019–2023.*

[4] Due to the weakness of its health system, WHO categorizes Lesotho as high risk and high vulnerability setting.

[5] Johns Hopkins University and Medicine Coronavirus Resource Centre https://coronavirus.jhu.edu/map.html, Retrieved: 04/04/2020

living with HIV, 24 percent are not on treatment, indicating a large proportion of the population may be immunocompromised and potentially at a higher risk of infection and its associated morbidity/ mortality. Limited access to essential public services, such as water, sanitation, and hygiene in certain areas, poses an extra risk for transmission of SARS-CoV-2.

Sectoral and Institutional Context

7. **Total government health spending has increased and is higher than in other countries.** Lesotho's total health expenditure is higher than in neighboring countries and has increased since 2010. Out-of-pocket expenditure by patients is 24 percent of the total, government expenditure is 44 percent, and external financing is 32 percent of total health expenditure (THE).[6] The Government spends 13 percent of its expenditures on health, above the average spent by upper-middle-income countries (UMICs). Lesotho's government expenditures on health reached 5.6 percent of GDP in 2014/16, which is considerably higher than the Sub-Saharan Africa average. The Government of Lesotho allocates the health budget by line items, such as wages and pharmaceuticals, and across cost centers at the central government, hospitals, and District Health Management Teams (DHMT). Health centers are under the purview of the DHMTs (sub-national level) and not considered as separate cost centers. Health expenditures occur at the cost center level (national level), facilitated through the financial management information system (FMIS) to ensure that actual expenditures are based on budget appropriations.

8. **Funding for nutrition specific interventions is limited**. Little is known about actual government expenditures on nutrition, as there is no budget line item for nutrition activities. Therefore, budgets tend to get allocated to other activities leaving nutrition program inadequately funded. Preliminary estimates suggest that government expenditures on nutrition-specific interventions increased by 31 percent from LSL 13.8 million in FY2014/2015 to LSL 18 million in FY2015/2016. It is also difficult to ascertain the expenditure on nutrition sensitive activities, as many of these interventions are financed through different government programs.

9. **Despite relatively high levels of health expenditure, the performance of the health system is weak and characterized by inefficient management**. In FY2016/17, recurrent expenditures in health were mainly to finance hospital care with contracted hospitals, including 29 percent on the Queen Mamohato Memorial Hospital (QMMH) public-private partnership (PPP) facilities network in Maseru, 17 percent on the Christian Health Association of Lesotho (CHAL) hospital network, and 15 percent for human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) care. A relatively small share of government spending went to district hospitals and district health. Primary health care centers are understaffed. The 2017 Health Public Expenditure Review found that DHMTs headed by the District Medical Officers have low budget absorption capacity with substantial underspending for 'medical material' for health centers. Actual 'in kind' support from DHMTs to facilities has been limited. DHMTs report aggregated expenditures across line items and not by health centers. Similarly, the Ministry of Health (MOH) pharmaceutical budget has only been partially executed (between 53 percent and 76 percent during FY2011/12–FY2016/17), resulting in regular stock-outs in health facilities. The government procurement process for commodities and equipment is extremely lengthy and can reach up to 70 days, resulting in delayed implementation and disbursement. Furthermore, the Government does not have a procurement audit system in place to monitor effectiveness and compliance of its procurement processes. In the absence of relevant medical material and staff, public health facilities provide low-quality care to

[6] World Bank and United Nations Children's Fund (UNICEF). 2017. *Health Public Expenditure Review.*

patients. To receive better care, patients circumvent public facilities to seek care in the more expensive tertiary care QMMH network.

10. **Health and Nutrition Outcomes - Health and nutrition outcomes are poor which puts the population at high risk to any pandemic.** Maternal and infant mortality ratios are still high.[7] Low birth weight prevalence was 14.6 percent in 2015.[8] Overweight and obesity prevalence among females stands at 45.3 percent and 20.4 percent respectively[9]. 27.4 percent of women have anemia and 9.9 percent of women have diabetes, compared to 7.3 percent of men. In 2018, HIV prevalence among adults (ages 15 to 59 years) was 25.6 percent and considerably higher among women (30.4 percent) than men (20.8 percent). HIV/AIDS and depressive disorders are the two diseases that contribute most to disability.[10] HIV/AIDS also remains the top reason for premature death, followed by tuberculosis, lower respiratory infections, and diarrheal disease. These diseases make Lesotho's population highly susceptible to the ongoing COVID-19 pandemic. Total fertility rate has decreased. Fertility remains high among poorest women (4.2 children) and women with primary school or no education (3.4 children). About 10 percent of women experienced gender-based violence (GBV) in 2018 (Multiple Indicator Cluster Survey [MICS]). The upcoming DHS will provide updated results for mortality, nutrition, and key health indicators.

11. **Stunting is a widespread problem and coverage of nutrition services is low.** Malnutrition remains the main cause of deaths among children.[11] Stunting has decreased slightly but remains much higher compared to Eswatini (25 percent) and Zimbabwe (28 percent). Almost half (45 percent) of the adult population suffered from stunting as children. In seven out of ten districts, stunting rates exceed emergency thresholds of 30 percent.[12] Stunting is higher in rural than in urban areas (36 versus 28 percent) and among children aged 2–23 months. Child stunting is 13 percent higher in the richest households compared to 35 percent among the poorest. Stunting is highest (58 percent) among children of illiterate women and among children born to adolescent mothers (39 percent). Inadequate care, feeding practices, and environmental health all contribute to high stunting rates in young children. The prevalence of acute malnutrition (wasting) among children under five years old slightly declined from 5.5 percent to 2.8 percent over 10 years, between 2004 to 2014 (LDHS 2014; MICS 2019). Poor children are five times as likely to suffer from acute malnutrition.[13] There is also evidence of an increasingly important double burden of malnutrition, as 7 percent of children under five are overweight/obese; among these 21 percent of babies under 6 months are overweight/obese (MICS 2019).

12. **Adolescent and School Health - Limited access to reproductive health services for adolescent girls contributes to high teenage pregnancy rates.** Pregnancy among teenage girls (ages 15–19) has

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[7] National estimates from Demographic and Health Surveys (DHSs) 2009 and 2014 are 1,155 and 1,024 out of 100,000 live births, respectively.
[8] National estimates from DHSs 2009 and 2014 are 1,155 and 1,024 out of 100,000 live births, respectively.
[9] WHO (2016) Lesotho Diabetes Country Profile (https://www.who.int/diabetes/country-profiles/lso_en.pdf?ua=1)
[10] Lesotho: http://www.healthdata.org.
[11] According to the Cost of Hunger Study in Africa (COHA), over 19 percent of child mortality is associated with undernutrition, 17.7 percent of all repetitions in schools is associated with stunting, and stunted children achieve 3.6 years less in school.
[12] Mokhotlong (47 percent), Butha Buthe (40.3 percent), and Thaba-Tseka (40 percent) have the highest stunting rates, followed by Mohale's Hoek (38.1 percent), Quthing (34.3 percent), Qacha's Neck (32.2 percent), and Leribe (31 percent). Maseru's stunting rate at 29.9 percent is close to the emergency threshold level while Berea's and Mafeteng's stunting rates are 27.4 percent and 25.9 percent, respectively. Children of shorter mothers (less than 150 centimetres) also had a higher stunting rate (43.8 percent) compared to those born to taller mothers.
[13] Global Nutrition Report (2018).

remained on a similarly high level at 17.8 percent.[14] Rates are considerably higher among poorest girls (25 percent), girls with primary or no education (32 percent), and girls who live in the foothills (37 percent). Teenage pregnancies are high-risk pregnancies that more likely lead to delivery complications; neonatal, infant, and under-five mortality; maternal mortality; increased risk of anemia and low birth weight, which increases the risk for child stunting. The use of modern contraceptive methods among adolescent girls increased from 17 percent in 2014[15] to 45 percent in 2018.[16] Increasing method choices for girls and women raises overall contraceptive use due to increasing distribution points and higher chances that women will find a method acceptable to their lifestyle and health needs. The World Health Organization (WHO) recommends that adolescents should be offered long-acting reversible contraception including implants and intrauterine devices.

13. **Adolescents are not adequately informed about HIV/AIDS, leading to high incidence, particularly among girls.** Despite high HIV/AIDS rates, only 38 percent of young women and 31 percent of young men knew about HIV prevention. Approximately 13,000 children ages 0 to 14 years (or 2.6 percent) are living with HIV. More worrisome, the 2018 Lesotho Population-based HIV Impact Assessment reports an already similarly high HIV incidence rate of 1.8 percent for 15–24-year-old girls and adults. As a result, the disparity in HIV prevalence by gender is most pronounced among young adults: in 2018, HIV prevalence among 20–24-year-olds was four times as high among females (16.7 percent) as among males (4 percent). Adolescent girls who reside in a rural drought area are more likely to contract HIV. Tragically, HIV prevalence is 19 percent among girls and young women who have been physically forced to have sex. The cultural, economic, social, and legal barriers that obstruct girls' and women's empowerment[17] must be addressed to ensure that adolescent girls have access to reproductive health care and a healthy future. With COVID, adolescent friendly services have been disrupted in much of the country and pregnancy rate among adolescents also increased during the lockdown period with the closure of schools.[18]

14. **Common school health interventions such as reproductive health counseling including comprehensive sexuality education, as well as classroom education about nutrition, are not offered.** Health outreach workers do not visit secondary schools. Students are sensitized on health and nutrition services they would need and are then referred to health facilities or health mobile units. The Ministry of Education and Training (MOET) recently piloted an Interactive Media, Peer Assistance, and Coaching for Teens (IMPACT) school health education program with support from the WHO. The program uses a peer-to-peer approach where nursing students provide services for sexual and reproductive health, HIV/AIDS, and life skills education to school students using education and appropriate technology to convey health information. The IMPACT pilot had a positive impact on students' behavior and outlook on life. Students are motivated and actively participate in the program. Scaling up the initiative would require more resources to finance information technology equipment and operational costs.

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[14] MICS 2018.
[15] LDHS 2014.
[16] MICS 2018.
[17] Kalimo, Kali. 2018. "Women Empowerment in Lesotho: Reality and/or Myth?" *Arts and Social Sciences Journal* 09. 10.4172/2151-6200.1000373.
[18] GoL COVID-19 Response Committee. (2021). Maintenance of Essential Services Amid C19: The Framework for Building Health System Resilience.

15. **Well-targeted investments in the health and nutritional status of adolescents can help break the intergenerational cycle of malnutrition and poverty and contribute to Lesotho's human capital.** Addressing adolescent health in non-formal education (NFE) could help reach more young people. Boys in Lesotho are more likely to drop out of school than girls and engage in child labor. The recently approved NFE policy provides literacy/numeracy and continuing education programs through distance learning to non-enrolled children, illiterate youth, and school dropouts. Almost 300 government-owned learning posts for literacy are administered by learning program administrators who are paid LSL 400 stipend per month. The Government also owns the Lesotho Distance Teaching Center in each district for continuing education. There are few health initiatives such as HIV/AIDS readers for literacy programs and a lifestyle skills module in the continuing education program. These initiatives could be expanded to teach about nutrition and reproductive health to students, teachers, program administrators, and part-time tutors.

16. **Community Health and Nutrition Services - In addition to insufficient funding, limited capacity and coordination between the community and central levels contributes to low coverage of nutrition interventions.** There are a large cadre of village health workers (VHWs) who deliver nutrition interventions in communities across the country. Nutrition programs, particularly infant and young child feeding (IYCF) counselling services, are provided at the community level through home visits and the nutrition clubs for complementary feeding. However, there is no information available on the coverage of these platforms or their effectiveness. The health sector organizes outreach services such as the child health days that deliver immunization and family planning services at the community level. But there is no systematic community-based approach to deliver preventive health and nutrition services or a strong referral system that links communities to health facilities. Strong collaboration between the health system and these community-based systems and informal structures, VHWs[19] and women's volunteer/support groups would be needed to strengthen primary health care, and preventive services, and to ensure their sustainability and effectiveness in improving health and nutrition outcomes. In 2018, the coverage of nutrition-specific interventions ranged from 31 percent to 58 percent, with lower coverage in districts with high levels of child stunting. COVID-19 has already had a negative impact on the delivery of community health and nutrition services due to fears of infection, and lack of personal protective equipment (PPE) for VHWs.

17. **Facility-based Services Delivery - The Government aims to strengthen clinical nutrition services in health facilities.** The integrated management of acute malnutrition has been scaled up to all health facilities, with efforts currently under way to improve documentation of outcomes for treatment. However, little information exists on the provision of other nutrition services at health facilities. COVID-19 has affected the delivery of services in health facilities across the country. The pandemic has led to a decline in the delivery and utilization of essential child, maternal and newborn services. Emergency services and prevention and treatment of communicable and non-communicable diseases have also been greatly affected. This is due to a temporary closure of some health facilities and re-deployment of staff to support the response to COVID-19. Utilization of services has also been affected due to community fears of contracting COVID-19 at health facilities. Outpatient and inpatient services have declined significantly since March 2020 with greater decline in Maseru, Qacha and Thaba-Tseka districts.

18. **Low quality of care in public health facilities leads to low service use, which the Government aims to address.** Lesotho's high maternal mortality rate suggests issues in timeliness, access, and quality

[19] See annex 6 for description of VHW role.

of care.[20] In 2014, 54 percent of pregnant women did not receive their first antenatal care (ANC) visit during the first trimester. Only 6 out of 20 secondary hospitals (where nearly half of deliveries occur) provided comprehensive emergency obstetric and newborn care (CeMONC) to ensure safe delivery.[21] A lack of qualified staff, preparedness, shortages, and a general negative perception of service quality[22] have contributed to a low average bed occupancy rate of 32 percent in public district hospitals. To improve infrastructure and availability of care, the Millennium Challenge Corporation (MCC) has upgraded and equipped 138 of 145 health facilities,[23] but facilities still report equipment gaps. The MOH has initiated the procurement for some equipment for hospitals to address these gaps. A facility certification system is being considered based on a star rating system that measures progress in the quality performance in health facilities. Better quality will lead to higher star ratings, and ratings are published for each facility.

19. **Patients bypass the public sector to seek better-quality care at the PPP referral hospital, which has contributed to higher government spending on hospital care.** The QMMH national referral hospital offers specialist, tertiary, and intensive care. The number of patients at the QMMH has greatly outpaced the expected demand. The most recent data shows, the QMMH reporting a 99 percent bed occupancy rate in 2018 and a growing number of patients with relatively low complexity.[24] These lower-complexity patients could be treated at lower cost in district hospitals if quality care were available. The Government reimburses the QMMH PPP hospital per patient treated. This payment mechanism combined with a high patient load at the QMMH has resulted in regular hospital budget overruns for the Government. The QMMH regularly reports to the MOH on its performance, including on admissions; however, these quarterly reports have not been used by the MOH to manage the patient flow and health expenditures.

20. **Performance-based financing (PBF) to health facilities built financial management capacity.** With the support from the previous World Bank-financed health project,[25] the Government tested a PBF approach in primary health centers and district hospitals in all 10 districts from January 2014 until March 2019. PBF reflects a shift away from the government's input-based financing approach to DHMTs to an output-based based approach by providing facilities a budget allocation directly against the provision of health services. A financial management protocol was developed, and capacity built in financial management across all participating health facilities nationwide.[26] Transaction records were maintained and leave an audit trail. A process mapping and bottleneck analysis of basic financial management processes found general compliance and recommended revisiting the manual and strengthening financial controls.[27] While PBF initiated an important fundamental reform to pay service providers directly, this was done outside the government budget management processes and required an expensive verification

[20] Pattinson, R. C. 2019. *LEAP for Quality: Final Report World Bank for Eight PBF Hospitals.*

[21] CeMONC Report 2015.
[22] Lesotho Health PER 2017.
[23] A United States Government financed infrastructure program targeting health, education, and water.
[24] Boston University (2020). Endline 2 Study for Queen Mamohato Memorial Hospital Public Private Partnership.
[25] Lesotho Health Sector Performance Enhancement Project.
[26] Capacity building included initiating requisitions, requesting quotations, raising purchase orders to suppliers, requiring a delivery note and invoice, initiating payment to suppliers through vouchers, actual payment through transfers, cheques or cash payments, receiving a receipt, recording of the transaction, and subsequently reporting.
[27] Ministry of Health (2020): Health Sector Performance – Performance Based Financing Project Financial Assessment: Financial management process mapping and bottleneck analysis report. Lesotho.

process. The mainstreaming of these practices into general government budget management is thus paramount.

21. **PBF combined with quality training has increased attention to service quality.** Health care personnel also benefited from continuous training on maternal and newborn care and the integrated management of childhood illnesses. Quarterly hospital quality checklists were introduced. Attention was paid to the treatment of severe acute malnutrition (SAM) through the introduction of the WHO 10 steps to treat SAM in participating hospitals. These quality improvement interventions could be extended to all health facilities, to ensure that all health staff are skilled in the management of malnutrition including SAM.[28] Referral data from the QMMH show fewer maternal deaths among patients who were referred from participating hospitals (63 percent) than non-enrolled hospitals (88 percent), suggesting better management of maternal care.

22. **PBF to health facilities has not been sustained and will be revised to ensure better quality care.** PBF has encountered challenges including: (a) budget and management issues resulting in shortages of supplies; (b) inadequate human resources for health and equipment; and (c) costly administration and verification of data that prevented the Government from sustaining the approach through its systems. As a result, PBF was not continued. The Government decided to introduce a simpler approach to reward better quality of care and develop sustainable financing for district health services with government resources. The goal is to build on the previous project experience, in particular the strong investment in quality of care and data collection, and to continue to send budget allocations directly to service providers using the basic financial management processes to ensure that providers have the resources to deliver better quality care.

Governance of Health and an Enabling Environment for Nutrition

23. **Stronger stewardship would help improve efficiency and equity and generate better health and nutrition outcomes.** The MOH is responsible for policy formulation, procurement of medical equipment and supplies, and management of health staff. The Government has already adopted the National Health Sector Strategic Plan to ensure equity and access to quality health services. However, governance of the health sector is weak. There is now a renewed effort to improve the effectiveness of existing local administrative entities. Insufficient capacity at the MOH has led to substantial delays in medical procurement[29] and staffing decisions, which limits health service provision. Inadequate health workforce management has contributed to substantial staff shortages. Relevant health policies and strategies have remained in draft form for almost a decade. For instance, the adoption of the VHW Program policy was delayed for a long while as revisions had to be made to the training curriculum. However, it was finally adopted in November 2019. The policy aims to help standardize profiles and tasks for VHWs, as well as responsibilities and oversight arrangements.

24. **A stronger stewardship function is needed to manage the health sector.** The government-financed health and nutrition benefit package and its' implementation modalities have not been well-defined. Referral guidelines do not exist and there is no clear policy about which type of treatment is to be provided at what level of care. Consequently, patients bypass health centers and district hospitals to seek care directly at the costlier QMMH. Also, there is no treatment abroad policy that defines which

[28] Pattinson, R. C. 2019. *LEAP for Quality: Final Report World Bank for Eight PBF Hospitals.*

[29] Implementation Completion and Results Report 2019: Lesotho Health Sector Performance Enhancement Project (P114589).

patients will be sent to hospitals abroad for treatment. In the absence of relevant policies and guidelines, health providers provide more expensive care, with compromised quality. As a result, the Government spends a growing amount for care at the QMMH referral hospital and for treatment abroad. The 2017 PER recommended referral analysis between district hospitals and QMMHs to improve the referral system. Referral guidelines for providers would help manage the patient flow.

25. **Stronger data collection and M&E capacity at the MOH will provide evidence for policy decisions.** The 2017 Health PER recommended that the Government should build institutional capacity to collect, validate, and utilize evidence on health and nutrition outcomes, service delivery performance, health and nutrition expenditures, to guide decision making. During the past two years, the MOH has rolled out the health management information system (HMIS) to monitor common health and nutrition performance indicators. In the future, the MOH plans to analyze this data to track program performance and financial reports to address issues related to efficiency, quality, and outcomes at different levels of care. Regular analysis would also help the MOH predict when the QMMH will be surpassing the agreed patient volumes, and it will inform government policy to revise health financing, quality of care and service delivery to health facilities at the sub-national levels.

26. **Human capital development is a top priority for the Government.** Under the leadership of His Majesty King Letsie III, Lesotho has expressed a strong political commitment toward working in human capital development and is engaged in the global dialogue on nutrition. During the high-level forum on Early Childhood Nutrition in Southern Africa: Investing in Healthy Children for Healthy Countries held in Lesotho in October 2018, the Government pledged to accelerate efforts to address child malnutrition to achieve the Sustainable Development Goal 2.2. The Government has undertaken key steps to build an enabling environment for nutrition. The NSDP II includes a key pillar to strengthen human capital: health, nutrition, education and skills development. The Government has developed a Food Security Policy (2005), Food Security Action Plan (2007–2017), and the National Disaster Risk Reduction Policy (2011). In addition, the: (a) National Nutrition Policy (2016) provides strategic guidance to sectors on a comprehensive approach to address malnutrition using evidence-based strategies; (b) 2018 Zero Hunger Strategic Review provides policy and strategic frameworks to increase food and nutrition security; (c) Lesotho Nutrition Improvement Design Framework (2017) focuses on stakeholder roles, possible contributions, and industry/sector-specific value propositions; and (d) National Food and Nutrition Strategy and Costed Action Plan 2018–2022 aims to reduce child stunting through a multisectoral approach and aims to increase resource allocation for nutrition to 3 percent of the national budget. Lesotho has been part of the Scaling Up Nutrition (SUN) movement since 2014.

27. **In sum, the Government spends a relatively high share of its resources on the health sector, but health and nutrition outcomes are lagging.** As shown in **Error! Reference source not found.**, life expectancy is only 50 years and stunting rates are the highest in the subregion. Lesotho has one of the highest maternal and child mortality and HIV/AIDS rates, high adolescent fertility, high malnutrition (under nutrition, micronutrient deficiencies and overweight/obesity) and a growing burden of noncommunicable diseases (NCDs). These outcomes are driven by a combination of factors including widespread poverty, poor financing for nutrition within the health sector, weak capacity at the Government to govern, deliver effective health and nutrition services , inadequate quality of care in health facilities, limited capacity for M&E in health and nutrition, insufficient coordination and limited communication with communities about relevant health and nutrition priorities. During the past years, the Government in collaboration with donors has had a strong focus on controlling the HIV/AIDS epidemic

and now the COVID pandemic. Broader health system and capacity constraints, and the malnutrition agenda have received less attention. The Government recognizes these problems and strives to achieve more value for spending through health sector reforms. Moreover, it is critical that essential health and nutrition services that have been disrupted due to COVID-19 are restored so as not to lose the gains made previously.

28. **The Government has sought World Bank assistance to support activities and the reform process in health and nutrition.** Previous World Bank support to Lesotho's health sector consisted of relatively small projects implemented over the last decade with a narrow focus. To improve health outcomes in the long run, the Government has requested a substantial increase in World Bank support to the health sector to help initiate and sustain the reform process. The World Bank will work with the Government to sustain reforms aimed at improved efficiency of health spending overtime, starting with better-quality service delivery in public health facilities, adjusting financial incentives to providers, and strengthening the MOH's governance and management capacity of the health sector. In nutrition, the focus will be on supporting the delivery of nutrition-specific interventions at scale and on strengthening coordination mechanisms between health and nutrition programs. The Government chose these areas as priorities given their relevance for better human capital outcomes, government commitment, and other donors' support in health and nutrition. This project is being prepared amidst the global COVID-19 pandemic. The Project support is aligned with World Bank and other donors' emergency support to the COVID-19 pandemic to ensure synergies and strengthen the resilience of Lesotho's health system, including a comprehensive response to the health and nutrition needs of women and children.

C. Proposed Development Objective(s)

Development Objective(s) (From PAD)

The objective is to increase the utilization and quality of key nutrition and health services and improve selected nutrition behaviors known to reduce stunting.

Key Results

PDO Level Indicators

Utilization and quality of nutrition and health services

(a) Women ages 15–49 who took iron tablets for 90+ days during the pregnancy of the most recent birth (Percentage).

(b) Women ages 15–19 currently using a modern contraceptive method (Percentage).

Selected nutrition behaviors known to reduce stunting

(c) Children ages 6–23 months with minimum dietary diversity (Percentage).

(d) Children under 6 months exclusively breastfed (Percentage).

Quality of health service delivery

(e) Women with institutional deliveries (Percentage).

(f) Health facilities certified as Level 2 or above with quality rating system (Percentage).

(g) Bed occupancy rate in regional and district hospitals (Percentage).

D. Project Description

29. This proposed, five-year investment project consists of three interlinked components and a CERC. The first component of the Project will be co-financed by a US$4.4 million grant from the Scaling Up Nutrition (SUN) Power of Nutrition (PoN) Trust Fund. The Project builds on the lessons learnt from previous World Bank financed programs.

Component 1: Community-Based Health and Nutrition Services (US$14.6 million of which US$10.2 million equivalent from IDA and US$4.4 million Grant from PoN Trust Fund)

30. This component would support a package of nutrition-specific interventions targeted towards women, children and adolescents that would be implemented at the community level. Activities will support the implementation of Lesotho's National Food and Nutrition Strategy and the VHW Program Policy to improve community-based nutrition service delivery and deliver harmonized behavior change messages through various platforms. Activities of this component will be implemented in all the nine districts (except Mokhotlong) as these districts have very high stunting rates. Mokhotlong will be supported through the Lesotho Highland Water Project (LHWP) as part of the social responsibility during the construction of Polihali dam. All activities be first piloted in the first 1.5 years in in three districts (Butha-Buthe, Maseru, and Thaba Tseka), before a rollout in the remaining districts. The lessons learnt from the pilot districts will be used to strengthen program implementation in the remaining districts.

31. **Subcomponent 1.1: Strengthening the community level functions.** This subcomponent will support the coordination of nutrition and health service delivery at the community level. It will help strengthen the functions of VHWs who would form the core of the community-based service delivery mechanism and will be attached to the primary health care centers (see annex 5). In view of the ongoing COVID-19 pandemic, VHWs will be supported to safely provide services in the community while minimizing the risk of transmission. Technical assistance will support the MOH in rolling out the VHW policy, establishing and coordinating the community-based nutrition and health service delivery platform, and building a fluid information system that will be used to strengthen the program. By strengthening the local village health committees, the MOH and FNCO would also be supported in coordination and managing a nation-wide community-based health and nutrition program including finding local solutions and use of local resources to address the bottlenecks. The Project will not support the payment of stipends to the VHWs. A Biometric and Payroll Census was conducted from July 2018 - January 2019 to identify and provide an accurate headcount of existing VHWs. VHWs will be trained by the MOH and supported to deliver a comprehensive set of health and nutrition interventions aimed at pregnant and lactating women, children under two years, adolescents, and families. Training will also include precautions against COVID-19 during service delivery in the community. Core VHW activities would include growth monitoring of children under five years of age, counselling of mothers and families on breastfeeding and complementary feeding as well as maternal nutrition. Both complementary feeding and maternal nutrition related activities will be done in coordination with Nutrition Clubs under the agriculture resource centers. VHWs would also support (i) early childhood development and psychosocial stimulation of infants during home visits (keeping in mind COVID related precautions), (ii) health center nurses during immunization outreach, (iii) GBV prevention through local councils, (iv) provision of social and behavioral change communication during home visits, including messages on COVID-19 prevention; and (v) provision of daycare to Centers hosting factory workers' young children in Maseru (industrial area) and Leribe (Maputsoe).

32. The rollout of the VHW policy will also include VHW contracting and initial and refresher trainings. The subcomponent would finance, toolkits, for VHW activities which will include supplies and commodities like baby weighing scales and other growth monitoring equipment, micronutrient supplements, communication materials, family planning materials etc. The Bank financed COVID-19 operation will provide part of the mobile phones to the VHWs and

establish a basic electronic reporting system to aid in data collection. The Project will therefore make use of the same system and support the addition of data collection modules for nutrition and MNCH. This data from the VHWs would then be reported in the MOH's HMIS.

33. **Subcomponent 1.2: Improving Adolescent Health and Nutrition.** The provision of health and nutrition education targeting adolescent boys and girls ages 10–19 will be supported through schools and NFE centers. The establishment and revitalization of youth peer educators, youth clubs, and adolescent health corners in communities will be supported. As part of the school health program, the MOET's IMPACT school health education program will be supported and scaled up to provide information, education, and communication services using social media and digital platforms, as appropriate. Key services and messages would be focused on health and nutrition, including prevention of early pregnancy and possibly provision of micronutrient supplements for both girls and boys. The revision of the 'Extracurricular Risk Reduction and Avoidance Handbook for Youth' to include health and nutrition information will be supported. Messages from the book will also be disseminated using mobile and other digital technology. Teachers and tutors will be supported to improve their skills in health and nutrition education. Relevant TA, logistics, and goods and services for the schools, NFE centers, and health centers will be provided.

Component 2: District Level Health System Strengthening (US$8.0 million equivalent from the IDA)

34. This component aims to improve the capacity of government and primary and secondary health care providers to deliver better-quality reproductive, maternal, newborn, child, and adolescent health and nutrition (RMNCAH-N) services in an efficient and effective manner. The component will be implemented in close collaboration with World Bank support to strengthen governance, public financial management (PFM), and the Government's efforts to improve the effectiveness of existing local administrative entities.[30]

35. **Subcomponent 2.1: Quality Improvement Grant.** This subcomponent will finance the provision of quality grants to all public and CHAL health facilities, using the government's finance system and based on the lessons learned from the previous Health Sector Performance Enhancement Project. The Project would support the quality grants only for the first two years of the Project, while providing TA to enable the government to take over the grant payments in the latter years. The sub-component would include: (a) a quarterly **quality payment** to finance the implementation of facility-specific quality improvement plans (QIPs); and (b) an optional annual **bonus payment** for the best performing health facilities with regard to coverage, quality, and efficiency indicators. The goal of quality payment will be to support the basic inputs required to ensure quality at lower level facilities which remain seriously underfunded. At the same time, the bonus payment aims to expand government focus from input-based to output-based payments to include efficiency, equity, and quality in the provision of care. The quality payment will be defined based on the latest quality score and remoteness and paid in two tranches each year – the first after health facilities have presented their QIPs and the second after the presentation of their mid-year QIP results. The quality payment is a grant to health facilities to increase their operating budget. The bonus payments will be paid quarterly to a certain number of winning health facilities; for instance, those with : (a) the best performance; and (b) the greatest improvement on a limited number of randomly selected Maternal Newborn Child Health (MNCH) indicators that best reflect the performance of the health providers. The MNCH indicators will be computed based on data that cannot be manipulated by health providers. A few indicators will be selected randomly from a certain number of indicators, and thus providers will not know in advance which indicators will be selected for the bonus payment. This reduces any incentive to manipulate indicators and at the same time sets an incentive to perform well on all indicators. The MOH M&E team will regularly review the data

[30] The Public Sector Modernization Project and the follow-up project.

reported in the HMIS to evaluate indicator performance with the technical support provided under Subcomponent 3.2. The details of the quality and bonus grant program will be outlined in the program manual.

36. **The project will finance the design, implementation, and M&E of both payments.** The quality and bonus payment will disburse to the quality improvement budget line in the MoH's recurrent budget (rather than the development budget), which the Government will need to create. Once the Government takes over the quality and bonus scheme at the Project mid-point, it will channel its' funds through this budget line, hence contributing to the scheme's sustainability. This budget line will allow cash transfers from the Central Government through districts to bank accounts that have already been opened by all health facilities with the support of the previous World Bank financed health project. Health facilities will follow the same financial reporting rules as under the previous health project's PBF component. Funds will be accounted for as grants to specific providers. Service providers will utilize these quality and bonus grants against protocols, and account and report against these with support from DHMTs. The use of grants will be subject to regular audits. As the FMIS system is deployed to hospitals but not to health centers, the FMIS cannot be used to execute all transactions. Instead, fund flows to health centers will be recorded as grants in the FMIS and will have to be accounted for through manual ledgers, compiled and reviewed on an annual basis. This means that ex-ante commitment control can be ensured through the FMIS for the grant provision, but not for the actual utilization of grant funds in health centers. The Government will define annual milestones for increased co-financing for both grants. The Project support will help the Government institutionalize the quality and bonus payment.

37. **TA to strengthen public financial reporting in health facilities and the MOH will be provided.** Health facilities will manage both payments autonomously and will spend the funds in line with their quality improvement objectives and work plans. Health facilities will have financial autonomy on the use of the quality and bonus payments based on financial spending and reporting guidelines. Health facilities will report expenditures using a cashbook accompanied with receipts. Facility managers can use their quality and bonus payments to finance inputs needed for the provision of care outlined in the QIP including: additional equipment needed for the provision of: (a) ANC care, postnatal care, nutrition counseling, and family planning ; (b) adolescent health programs; and (c) community outreach services The project will finance TA to support the recommended financial management changes based on the recent MOH assessment. The TA would also strengthen financial management (FM) in health facilities, internal audits, and M&E of the relevant indicators in health facilities. The project will support the development of a web-based module to report and track quality and bonus payments and indicator results by health facilities. Results will be complemented by indicators collected by the District Health Information System 2 (DHIS2).

38. **Subcomponent 2.2: Quality Improvement Training and Equipment.** This subcomponent would finance the provision of obstetric equipment including baby weighing scales and supplies for all 17 district hospitals based on a gap assessment.[31] Family planning commodities, micronutrient supplements, and therapeutic feeding treatment for moderate acute malnutrition and SAM would also be provided to the hospitals and health centers. It will also finance TA to train health staff and management on the use of the new equipment where needed. Building on the experience and quality improvement training provided under the previous Health Sector Performance Enhancement project, the subcomponent will finance TA on continuous medical education for health facility staff, including on treatment protocols related to selected RMNCHA-N, NCDs, mental health for pregnant women and mothers, and emergency care. Furthermore, to ensure the capacity of the future health workforce, the subcomponent will support the National Health Training Center in the education of nurses and allied health personnel, by financing TA for curriculum reforms and basic teaching equipment for pre-service training. Training and assessment modalities would be supported, including e-

[31] The gap assessment would use the WHO checklist for basic equipment for maternal and child health care and the treatment of most common diseases and pandemics.

learning platforms and digital evaluation tools for current and future health staff. Training will include efforts to improve the quality and coverage of birth weight measurements during facility deliveries. Lastly, the sub-component will finance the digitization of the Lesotho Logistics Management Information System (LMIS) to ensure better monitoring of availability of medicines.

Component 3. Strengthen Government Stewardship, Project Management, and M&E (IDA: US$3.6 million equivalent)

39. **Subcomponent 3.1: Building a Nutrition-Enabling Environment through Strengthening the FNCO.** This sub-component will support a nutrition-enabling environment through technical assistance to the FNCO to: (a) conduct multisectoral advocacy for nutrition by reviving the National Nutrition Commission to enhance awareness on nutrition financing and technical nutrition issues amongst the parliamentarians, politicians, media, senior government officials, traditional leaders and community councils; (b) support drafting and finalization of the Infant Milk Substitutes (IMS) code and Maternity Protection Bill to protect, promote and support exclusive breastfeeding; (c) support FNCO to develop a national nutrition plan with yearly targets at the national and subnational levels; (d) support MOH to establish a consolidated nutrition database to collate, analyze data and use this information to monitor and track nutrition progress at the national and sub-national levels. TA will also be provided to help establish the community leadership team composed of councilors, local authorities, and chiefs so that they are involved in the community mobilization and accountability on the results. The TA would also support citizen engagement and the establishment of a beneficiary feedback mechanism.

40. **Subcomponent 3.2: MOH Stewardship and M&E Capacities.** This subcomponent will finance TA to the MOH to develop and implement policies, strategies, and guidelines that will help improve the effectiveness of the sector and build capacity in managing health care. These include: (a) the Referral Guidelines for providers to refer patients across levels of care and for treatment abroad; (b) the Quality of Care Strategic Plan, which includes, *inter alia,* the establishment of a facility quality certification system (for example, 'star rating' scheme). Building on the QIP and quality and bonus payment the quality certification system will allow measuring progress in the quality performance by health facilities while at the same time strengthening the MOH's Quality Assurance Unit's capacity for quality assessment, supervision of care, and mentorship programs; (c) restructuring the strategic purchasing payment mechanism and develop standards operating procedures and guidelines for contract management for all health services' suppliers.

41. **This subcomponent will also finance TA to the MOH to support data collection and M&E capacity.** TA to the MOH will include the following: health and nutrition financing analyses, such as analysis of quality and bonus payments; performance of QMMH, Christian Health Association of Lesotho (CHAL), and public health providers; and nutrition expenditure analysis. It will also support Annual Joint Reviews to consolidate findings. Capacity transfer to the M&E staff at the Ministry of Health to conduct these tasks autonomously will be prioritized.

42. **Subcomponent 3.3: Project Management.** This subcomponent will finance the expenses associated with the implementation and management of the project at the central and district levels. Recurrent costs, office equipment and furniture, consultant salaries, travel expenses, training of project implementation staff at the central and district levels, M&E, and project financial audits will be supported. The Project Implementation Unit (PIU) will coordinate with the MOH and, FNCO, to plan and implement project activities and track progress through project monitoring data, progress reports, audits, and other assessments. Data collection, assessments, and studies including health and nutrition surveys will be supported. The project would co-finance national surveys, such as the DHS in 2021 which will provide baseline values for the results framework, and the planned DHS 2025 which would provide end line data. The DHS includes a

comprehensive module on nutrition and GBV. Data collection will be optimized and coordinated for analyses under the project.

Component 4. Contingency Emergency Response Component (CERC) (IDA: US$0.0 million)

43. In the event of an eligible crisis or emergency, the project will contribute to providing immediate and effective response to the said crisis or emergency under this CERC.

Legal Operational Policies

	Triggered?
Projects on International Waterways OP 7.50	No
Projects in Disputed Areas OP 7.60	No

Summary of Assessment of Environmental and Social Risks and Impacts

The Project will not support any development of infrastructure or fund construction activities. The proposed project will mainly provide technical assistance aimed at strengthening the overall health system, supporting nutrition specific interventions for quality and efficiency and promoting adoption of healthy behaviors. These activities will have minimal environmental and social footprints. The overall environmental and social risk rating for the proposed Project is Moderate due to the nature of the proposed Project activities. The rating considers the limited capacity of the MOH and other key implementing agencies at both national, district and community levels in the application of the ESF and applicable Standards. The Project's impacts are related to the proposed improvement of health facility-based service delivery under Component 2 which will result in the increase of people accessing health facilities. Based on this, key environmental risks and impacts are related to (i) marginal increase of health care waste (ii) occupational health and safety of health care workers; and (iii) community health and safety related to the operation of health care facilities. The key social risks and impacts are related to labor and working conditions, prevalence of GBV and HIV/AIDS in the country, potential impacts to community health and safety, and the Client’s limited experience in implementing Bank funded projects. Potential impacts and risks are expected to be site specific, reversible and managed through: established and proven mitigation measures; capacity building activities aimed at strengthening the PIU to comply with the ESF requirements; implementation of environmental safeguards instruments prepared for the project and retaining the E&S Specialist engaged by the PIU to support the Project with the implementation of environmental and social mitigation measures.

E. Implementation

Institutional and Implementation Arrangements

44. **A single PIU at the MOH will be used.** Building on the lessons learned from previous health projects, the proposed institutional arrangements would be kept simple by having a single PIU at the MOH to implement the entire project. Involving multiple implementing agencies would create challenges and lead to delays in project implementation, particularly in a context of weak institutional capacity. The selected PIU is currently

implementing the World Bank-financed regional TB project and has been working with other sectors, that is, labor and employment, mining, and correctional facilities. The TB PIU will be strengthened to handle the additional technical areas, as well as fiduciary, monitoring, and coordination processes that will be required for implementing this Project.

45. **Participating agencies - the FNCO and MOET - will be responsible for the technical oversight of specific activities under the project** (for example, risk assessment, contributing to terms of references, and technical specifications). The FNCO will be responsible for the content of national- and local-level advocacy messages on reducing and preventing chronic malnutrition and leading the development of the National Nutrition Plan. The MOET will work closely with the MOH on the implementation of the school health education programs. The Ministries of Finance (MOF) and Development Planning (MODP) will provide oversight on the loan management as part of the World Bank-supported portfolio. The MOF will also work closely with the MOH on implementing the budget changes required to sustain the quality and bonus grant scheme. The PIU would perform fiduciary functions on behalf of participating institutions. All reporting and oversight relationships are defined in the Operations Manual, to be adopted before loan effectiveness.

46. **The PIU will coordinate with district - and community-level actors to strengthen buy-in to and relevance of the project.** Specifically, the PIU and the other institutions will coordinate with the District and Community Councils. The PIU will coordinate project interventions with the various institutions in charge of implementing activities. These include technical units of the MOH and MOET, and participating districts and communities/villages through the District and Community Councils. The MOH will focus on the implementation of nutrition-specific services, the MOET will be responsible for secondary school-related activities. At the local and community levels, the PIU will coordinate with district and community councils and local chiefs to increase ownership and adjust the interventions to the specific needs of each area.

47. Two committees will be established to oversee health nutrition activities under this project:

(a) A high-level steering committee comprising Directors in charge of nutrition activities from the MOH, and the FNCO. The committee will meet twice a year to advise the MOH, and FNCO on priorities and review progress. The goal is to: (i) advise and support scaling-up activities in a systematic manner; and (ii) take evidence-based decisions related to nutrition policies and activities.

(b) A technical committee comprising technical experts working at the Government. The technical committee would meet quarterly to review project implementation progress and recommend mid-course adjustments to the PIU, if needed. It will be headed by the Director of the FNCO.

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