



Project Information Document (PID)

Concept Stage | Date Prepared/Updated: 28-Jun-2019 | Report No: PIDC26364



BASIC INFORMATION

A. Basic Project Data

Country Eswatini	Project ID P168564	Parent Project ID (if any)	Project Name Eswatini Health System Strengthening Project (P168564)
Region AFRICA	Estimated Appraisal Date Sep 02, 2019	Estimated Board Date Dec 12, 2019	Practice Area (Lead) Health, Nutrition & Population
Financing Instrument Investment Project Financing	Borrower(s) Ministry of Finance	Implementing Agency Ministry of Health	

Proposed Development Objective(s)

The project development objective is to improve the quality and efficiency of health services delivery, with a focus on maternal and child health and non-communicable diseases.

PROJECT FINANCING DATA (US\$, Millions)

SUMMARY

Total Project Cost	20.00
Total Financing	20.00
of which IBRD/IDA	20.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Bank for Reconstruction and Development (IBRD)	20.00
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Environmental and Social Risk Classification
Moderate

Concept Review Decision
Track II-The review did authorize the preparation to continue



Other Decision (as needed)

B. Introduction and Context

Country Context

The Kingdom of Eswatini is a landlocked, small open economy in Southern Africa, with a land area of 17,364 km² and a population of 1.34 million.¹ The country is mountainous with 78% of the population living in rural areas,² and an overall population growth rate of 1.8%. The country has four administrative regions: Hhohho (25.3% of total population), Manzini (39.4%), Shiselweni (15.1%) and Lubombo (20.3%).³ It has long been a peaceful and stable “monarchical democracy”, where absolute power rests with the monarch while traditional and parliamentary systems run concurrently.

Although classified as a lower middle-income country (GNI per capita US\$2,960), high rural poverty rates, regional variations in poverty, and income inequality challenge Eswatini’s economic and human development potential.⁴ The national poverty rate fell from 63.0 to 58.9% between 2010 and 2017. Yet, poverty prevalence remains high in rural areas (70%) and in two regions (Lubombo and Shiselweni, respectively at 71.5% and 67.3%). Poverty affects basic needs, with potential life-long effects. For example, 70% of households report moderate to severe food insecurity, particularly hazardous for pregnant women and children.

Economic growth declined from a 3.2% annual GDP growth in 2016 to 1.9% in 2017 and 0.2% in 2018. Forecasting indicates a -0.4% contraction for 2019, with a slow recovery, from 0.2% in 2020 up to 2.2% in 2024.⁵ Macroeconomic performance has been hampered by severe droughts and growing fiscal challenges. Declining government revenue and high expenditures resulted in high fiscal deficit and cash flow challenges.

As per the National Development Strategy, Vision 2022, the Kingdom aspires to be in the ‘top 10% of the medium human development group of countries’, founded on sustainable development, social justice and political stability. Progress⁶ to achieve this vision has been hampered by slow implementation, the 2010-11 fiscal crisis and the 2015-16 drought.

The country’s human capital potential is not fulfilled. Despite its middle-income status, the Human Capital Index (HCI) – a composite measure of survival of under-five children, educational attainment, and adult survival rate and stunting – is low, comparable to poorer countries. A child born today in Eswatini would be 41%⁷ as productive as s/he could be under complete health and education. Estimates show that by investing in human capital, the GDP per worker could be 2.4 times higher. To meet the vision for human development, about a 15-percentage point increase is required from Eswatini’s current HCI score, calling for improvements in health, nutrition and education services, and cross-sectoral synergies.

The government has committed to a ‘turnaround strategy’ to attain macrofiscal stabilization and growth. As part of the ‘turnaround strategy’ and recognizing the importance of human capital as a contributor to economic growth, in March 2019 the government joined the group of early adopters of the Human Capital Project (HCP). Investments in health, together with education and social protection and improved use of technology are strategic priorities for growth.

¹ WDI Country Profile, 2016

² United Nations Population Division, 2014-2015

³ Multiple Indicator Cluster Survey, Central Statistics Office, 2014

⁴ <https://data.worldbank.org/country/Eswatini> Atlas Method

⁵ http://macro-povertyoutlook.worldbank.org/mpo_files/data/data-am18-swz.pdf

⁶ Progress is measured using the Eswatini Development Index (EDI) measures progress towards achievement of Vision 2022 goals, focused on: i) economic prosperity, ii) agriculture and environmental sustainability, iii) education, iv) health, v) service delivery, vi) infrastructure, vii) governance, and viii) corruption.

⁷ The achievement on the HCI’s health dimensions are: probability of survival to age 5 = 95%; adult survival rate = 59%; not stunted rate = 74%.



Sectoral and Institutional Context

Eswatini's health outcomes are not commensurate with its spending on health (US\$233 per capita in 2015) and its middle-income status. This is related to i) the delayed response to the unfolding epidemiological transition resulting in misalignment between population health needs and health services; ii) health system challenges that hamper the effective and efficient delivery of health care, arising from a disproportionate focus on inputs and not enough on the production of high-quality services and health outcomes; and iii) inability of the health system to respond to patient expectations, signaled by frequent reports of drug shortages, waiting times, and so forth in health facilities

Eswatini faces a dual burden of disease. Despite progress, the HIV and TB co-epidemic and a persistently high maternal and neonatal mortality are compounded by an increasing pressure from non-communicable diseases (NCDs).

- **Eswatini has the highest HIV prevalence in the world, with more than a quarter of its reproductive age population (27.2%, 2017) living with HIV. HIV/AIDS and TB are the first and third leading cause of death, respectively.** High HIV prevalence contributes to poor maternal and child health (MCH) outcomes (33% of maternal death), increased co-morbidities with TB (70% co-infection), cervical cancer and other NCDs, such as diabetes and cardiovascular diseases. The cost of HIV response is on the rise due to increasing life expectancy, new treatment guidelines, and complex co-morbidities. This expenditure increase is set against increasing domestic fiscal constraints and declining aid from development partners. Although there has been a 44% reduction in new HIV infections and substantial decline in TB prevalence and incidence⁸, the urgency of the epidemic has created a vertical platform and fragmented the health system. Investments that have benefited the HIV and TB subsector have not reached the whole system, resulting in a two-tiered system with different capacity, management platforms, and a wide gap in performance.
- **Poor MCH outcomes have overwhelmed the country for decades despite improved access to antenatal care (95% 1st ANC) and deliveries attended by health personnel (88%),** as indicated by a Maternal Mortality Rate of 389/100,000 in 2015 and an Under 5 Mortality Rate of 54/1,000, driven by mortality under 1 year.⁹ Recent World Bank assessments suggest that maternal and neonatal service and health outcomes are curbed by poor quality of care and challenges along the continuum of care, throughout the pregnancy and the first 1,000 days of the child. The adolescent fertility rate, at 78 births per 1,000 women aged 15-19 years, is also a contributing factor to the MCH outcomes because these pregnancies are associated with higher risks for maternal and neonatal morbidity and mortality due to birth complications and nutritional aspects (lower birth weight and poorer nutrition in the critical early child years). Investments in modern infrastructure and equipment are not enough for excellence in service delivery and to reduce maternal and neonatal morbidity and mortality. Complementary investments are required in the health system, including how it is governed and managed, how services are organized and how providers are financed.
- **Despite the growing share of NCDs and related expenditure pressures, the sector has not focused on this threat and, thus far, has underinvested in skills and technology to respond to this burden.** NCDs as a cause of mortality grew from 24% in 2000 to 37% by 2016. In 2017, three of the top five causes of death included cardiovascular diseases, cancer, and diabetes and chronic kidney diseases. Yet, insufficient resources (financial, human, technical and managerial) have been dedicated to NCD care, resulting in avoidable morbidities and mortality, as well as excess costs. In contrast with the focused efforts and demonstrated success of responding to communicable diseases, service delivery for NCDs has been inadequate due to a combination of challenges along the cascade of care,¹⁰ including inadequate interventions for prevention, screening, availability of early diagnostic services, equipment and medicines for treatment, and lack of in-country / domestic specialists. An important underlying cause that prevents effective and efficient NCD response is the capacity and organization of the health system, discussed further below.

⁸ TB prevalence has declined from 1,382 per 100,000 population in 2013 to 308 in 2017 and incidence from 945 to 403 in the same period.

⁹ Infant Mortality Rate (2-12 months) of 41/1,000 in 2017, and a Neonatal Mortality Rate (0-2 months): 21/1,000 live births in 2015.

¹⁰ The care cascade includes prevention, screening, diagnosis, linkage to care, and treatment.



Eswatini's health system has benefited from significant investment in infrastructure and in programs. However, due to lack of commensurate investment in system organization and modernization, it has not been able to reach its potential in efficiency, quality and responsiveness to address population health needs because of challenges in three main areas:

- 1) ***Weak Sector Governance and Management.*** The Ministry of Health (MOH) is the principal ministry mandated to provide leadership in the production, delivery and utilization of health services. The system is centralized with limited autonomy at all levels. The stewardship / oversight function of the MOH is constrained due the complex relations with other ministries; its poor functional organization; and varying levels of policy-making and technical capacity of the MOH's directorates and programs. Within the sector, an inefficient tripartite structure (medical, nursing, and administrative cadres) has led to fragmented and weak institutional governance and management capacity, curbing coordination and decision-making functions at both MOH and facility level. Poor quality of much needed data requires urgent attention to improve evidence-based planning and policy making to efficiently deliver high quality care.
- 2) ***Misalignment of Budget and Results. Health expenditure as a share of total Central Government Expenditure and in real per capita terms have declined since 2015, posing a risk to progressing towards UHC.***¹¹ To improve sector performance through the financing channel, the MOH has not adequately harnessed: i) strengthening health intervention prioritization, that is, defining services by level of care that best improve population health outcomes for a defined budget envelope; ii) the potential of health service contracting or using well thought-out provider payment mechanisms that would link payments to results; and iii) enhanced public financial management in health to strengthen budget formulation, execution, and monitoring.
- 3) ***Service Delivery Challenges. The patient experience, when interacting with the health system is not matched to the quality of the infrastructure that now exists because of misalignment and mis-organization in service delivery.*** Sector performance is affected by organizational problems that cut across all levels of care, including: excess capacity at hospital level (average 45% bed occupancy rate), blurred hospital service profiles (hospitals delivering primary care), poor referral mechanism, and consumers by-passing the primary level. Although the system distinguishes five levels of care, service menus are not defined by levels. System-level challenges persist in rationalizing and harnessing the workforce, maintaining medical infrastructure and equipment, managing the drug and commodity supply chain, and tracing outcomes (patient, facility level and aggregated). There are significant gaps in specialists and specialized nurses¹² which affect responsiveness, health outcomes and costs. Beyond the numbers and alignment of HRH with priorities, challenges with staff deployment, rotation, retention, remuneration, and performance management have affected service delivery. The sector has been slow to adapt technology and tools to inform planning, service organization and delivery, and performance management. Recognizing these challenges, the MOH is committed to accelerating technology adoption and innovation to improve the frequency and quality of data flow to inform planning and service delivery optimization and strengthen accountability – all integral to excellence in service delivery and a client and results-centered system.

Eswatini's National Health Sector Strategic Plan III (NHSSP III) aims "to build an efficient, equitable, client-centered health system for accelerated attainment of the highest standard of health for all people in Eswatini." To meet the ambition under rising budget pressures, and to take the health system to the next level, the MOH will need to undertake strategic service delivery reorganization and purchasing reform to improve care quality, patient satisfaction and health outcomes, as well as to boost productivity and reduce wastage. This will require continuing the implementation of

¹¹ Due to fiscal pressures, in 2016 the health budget as a share of CGE decreased to 10.2%, and in 2017 to 9.1%, below the Abuja target (15%).

¹² One target of the EDI is nurses and midwives per 100,000 population, shows a declining trend, due to alignment (e.g. not training specialized nurses, brain drain to the private sector or other countries due to compensation differentials, inadequate task shifting).



complex system strengthening reforms, including improving sector governance and management; designing and operationalizing cost-effective service delivery models to better address the leading causes of mortality and morbidity; strengthening purchasing and contract management capacity; repurposing/aligning the health workforce with the changing sector context; investing in a digital health strategy and digital health platforms; generating reliable data flows, including on costs, facility-level performance, and health outcomes to inform purchasing, service organization and other policy and operational decisions; and engaging the mission and private sectors more strategically.

Relationship to CPF

The proposed project is aligned with the adjusted Country Partnership Strategy (CPS FY19-20) and will build on the strategic objectives of the CPS.¹³ Specifically, the proposed project will contribute to Pillar II (Strengthening State Capabilities) of the CPS, primarily through Objective 2 (Improved Social Services Delivery); and will coordinate with the other lending operations under preparation (Water & Sanitation and Energy) to harness cross-sectoral synergies. In response to the Government's request to become an early adopter of the Human Capital Project (HCP), the project will support Eswatini's progress in human capital formation, with focus on the health dimensions of the Human Capital Index. The proposed operation is also consistent with the IMF's technical report on expenditure rationalization (February 2019).

The proposed project design builds on a decade of engagement through Analytical and Advisory Services (P163653) and the Eswatini Health, HIV/AIDS and TB Project (P110156). As the first IBRD operation in human development in Eswatini, the previous project played an important role in developing critical infrastructure and strengthening the health/social protection systems between 2012-18. To build on the momentum, in collaboration with development partners and sectors active in the World Bank's operational portfolio, the proposed project will be a strategic investment to catalyze sector modernization to improve quality-adjusted effective service coverage and serve the population better and more efficiently.

C. Proposed Development Objective(s)

The project development objective is to improve the quality and efficiency of health services delivery, with a focus on maternal and child health and non-communicable diseases.

Key Results (From PCN)

Progress towards the achievement of the PDO will be measured by:

1. Health Facility Quality Index scored 0-100: average score for all health facilities¹⁴ will be computed with emphasis on process and outcome measures and less on structural measures
2. Percentage of outpatient visits which took place in Primary Health Care (PHC) facilities.¹⁵
3. Pregnant women receiving at least 4 ANC visits with defined quality standards (1st ANC in 1st Trimester; receiving the seven services;¹⁶ indication for high risk pregnancy assessed and marked)
4. Percentage of pregnant women delivering in health facilities providing Emergency Obstetric & Newborn Care (EmONC)
5. Number of people screened for NCDs (hypertension, diabetes, breast cancer, and cervical cancer)

D. Concept Description

In line with the NHSSP III focus on delivering quality care equitably, the project will support the following system

¹³ See more on the performance and Learning Review (PLR) for the CPS FY15-18, August 2, 2018. Report No: 126205-SZ

¹⁴ The quality scores with sub-indicators will be defined by level of care to adjust for differences in service profile.

¹⁵ Outpatient visits in PHC / Outpatient visit in all facilities (hospital + PHC)

¹⁶ Blood pressure, urine sample, blood sample for blood type, weight measured, height measured, iron supplement given, tested for HIV/AIDS.



strengthening interventions: (i) modernizing the service delivery model; (ii) introducing a purchasing function and improving payment methods to boost effectiveness and efficiency of service delivery; (iii) improving sector governance, management and performance, including through investing in tools and digital platforms; and (iv) improving the quality of health service delivery (professional, patient-oriented, and equitable). Through these interventions, the project will prepare the MOH to test and scale a new service delivery model, output-based financing approaches, and a digital health system. At the center of these system reform investments is the patient, and the measure of success is improved patient satisfaction and health outcomes.

The proposed project is an Investment Project Financing (IPF) of US\$20 million, covering all four regions of the Kingdom. To attain the PDO, the project will include three technical components. The fourth component is a Contingent Emergency Response Component (CERC).

Component 1. Strengthening Facilities to Deliver Quality Health Services (US\$14.5 million). Because investments in infrastructure without organizational changes are not enough to change patient-level outcomes, the thrust of this component is the facility-level application of an improved service model (hub and spoke), including operational procedures, investing in training the workforce, and technology. Specifically, Component 1 will focus on (i) supporting the facility and regional levels to implement the new service delivery model and the accompanying contracting solution; (ii) improving the quality of service delivery, measured through maternal and neonatal health (MNH) and NCD tracers; and (iii) investing in digital platforms and environmental health, including facility-level capital investments and process modernization to improve service quality and efficiency.

A. Health Service Reorganization and Improving the Quality of Service Delivery (US\$6.5 million). This subcomponent will support the implementation of service delivery reorganization, a proposed hub and spoke network model with improved referral mechanism and improved health financing (e.g. purchasing, contracting, provider payments) at the operational levels (facilities and regions). Implementing the new model will involve HRH alignment with service needs, including producing own specialists, technical and managerial capacity building and performance management to operationalize the modernized service delivery. The changes in the service delivery model will require consumer education, selected cost-effective demand-side interventions to induce behavior change in how services are used and valued. Demand-side interventions will be considered to sensitize the population to enforce care seeking at the appropriate level, use of referrals, brand specialized hospitals.

B. Investing in Digital Platforms and Processes of Care to Improve Quality and Efficiency (US\$8 million). This sub component will support improving: 1) the maintenance model and processes for medical equipment and infrastructure; 2) access to essential medicines through investing in supply chain management (e.g. nation-wide scale-up of the Electronic Logistical Management Information System, eLMIS; Operations Center to support vertical integration of medicines, lab, vaccines, etc.); 3) sector performance by investing in digital health management information system (system-wide scale-up of the Client Management Information System CMIS 2.0 including network, hardware, and software investments; strengthen data science skills); and 4) environmental health, including facility-level sanitation¹⁷ and health care waste management¹⁸. Tracers (MNH and selected NCDs) will be used to evaluate the impact of investments in these tools/digital platforms on service delivery, patient experience and health outcomes.

¹⁷ i) Technical Assistance (TA) to carry out an assessment of the status of sanitation systems at Mankayane Government Hospital, Dvokolwako Health Center, Mkhuzweni Health Center, Sithobeleni Health Center and Good Shepherd Hospital, and recommend and design suitable sanitation options for each health facility; ii) TA for preparing an ESMF (and generic ESMP) for the recommended sanitation designs; and iii) depending on the design and budget, procurement of contractors to build the recommended sanitation design for each selected facility.

¹⁸ i) TA for feasibility and economic cost analysis on options for treatment and disposal of infectious waste; ii) procure and locate waste skips at health centers for general waste and incinerator ash, and construct secure health care waste storage areas for facilities without appropriate waste storage; and iii) capacity building for health workers and facility staff at all health facilities on HCWM, waste minimization, OHS, and emergency preparedness and response.



Component 2. Strengthening Sector Governance and Performance (US\$4.0 million). This is a pivotal component, without which the impact of facility-level investments (Component 1) will not be effective and sustainable. This component targets the MOH to strengthen its stewardship function, policy-making and regulatory capacity, purchasing capacity, and will support engaging with the Central Agencies and other line ministries that are critical for the implementation of the proposed sector strengthening and modernization. Component 2 will focus on: (i) supporting policy-making in agreed target areas¹⁹ and the development of a comprehensive regulatory framework, including modernizing legislation and the establishment of the Directorate of Regulatory Services; (ii) the development of a health financing strategy, with focus on efficiency and sustainability (e.g. purchasing arrangements, payment reform), and supporting its implementation; (iii) redesigning the service delivery architecture applying a hub and spoke model, including reform of the hospital sector to foster specialization and productivity, improving the functionality of the referral system, and using the primary level more effectively and efficiently; and; (iv) support the development of an HRH strategy to unleash the potential of an improved health workforce, which requires engagement with the Ministry of Public Services and Ministry of Education; (v) develop a Health Care Waste Management Strategy; and (vi) strengthen the institutions and data science capacity for evaluation, including support for the implementation of the M&E Plan (2019-23), and introducing digital systems to ensure availability of high quality data for evidence-based decision making, thereby, improving effective (quality-adjusted) coverage and efficient service delivery.

To warrant effectiveness and sustainability, this component will provide tailored support to each implementing department/program through strengthening technical skills, managerial skills, and organizational changes (defining decision scope, accountability linkages, etc.), including change management. To reduce the dependency of MOH on partners, this component will also support institutional strengthening by twining arrangements with MOH staff.

Component 3. Project Management and Evaluation (US\$1.5 million). To ensure effective and efficient implementation, the proposed project will support the MOH with fiduciary aspects (financial management and procurement), project evaluation, and environmental and social safeguards. This component will ensure the timely management of procurement of goods and services, financial reporting and audits, consistent and quality data flows for the Results Framework and operational research purposes, compliance with environmental and social requirements and the Environmental and Social Commitment Plan (ESCP).

Component 4. Contingent Emergency Response Component (CERC) (US\$0). This CERC is included under the project in accordance with Bank Policy: Investment Project Financing, paragraphs 12 and 13, for situations of urgent need of assistance. This will allow for rapid reallocation of project proceeds in the event of a future natural or man-made disaster or crisis that has caused or is likely to imminently cause a major adverse economic and/or social impact during the life of the project. This component will have no funding allocation initially. In the event of a future emergency, this component would allow the Government to request the World Bank to recategorize and reallocate financing from other project components to cover emergency response and recovery costs, if approved by the World Bank.

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

¹⁹ E.g. promulgation of National HCWM Regulations, Policy on Private Sector Engagement, HRH Strategy, Digital Health Strategy, NCD Strategy, etc.



Summary of Screening of Environmental and Social Risks and Impacts

Environmental risk classification of the project is moderate. Specific areas identified for modernizing and strengthening delivery of health care services (legislation, policies, strategies, information systems, and preparation of a Health Care Waste Management Strategy) will largely bring positive environmental impacts to the health sector in Eswatini. The project will also support small scale civil works related to sanitation and management of health care waste. However, at this concept stage, these activities have not been identified yet, and therefore, their nature, scope, and geographical locations are not yet known to enable determination of specific environmental risks and impacts associated with the activities. Environmental risks and impacts inherent to such activities are associated with typical small-scale civil works during rehabilitation occurring within the footprint of existing facilities, and those associated with management medical waste during operation. The environmental risks and impacts associated with these activities are minor, short-term, and will be managed through an Environmental and Social Management Framework (ESMF) to be prepared by the Ministry of Health before appraisal, including a generic Environmental and Social Management Plan (ESMP) and standard contract clauses for small civil works. A Health Care Waste Management Plan (HCWMP) was prepared as part of the closed project providing guidelines for comprehensive health care waste management to prevent, reduce and mitigate environmental health impacts on staff and the public.

The social risk rating of the Project is considered to be moderate at this stage as the Project does not involve any significant social impacts that could harm communities and individuals. The project footprint is relatively small with limited amount of labour and construction activities (waste water treatment and disposal facilities) will be undertaken in land already owned by benefiting institutions as project beneficiaries (e.g. clinics, hospital, etc). Key social concerns include possible minor land acquisition/restricted land use or access to land for the centralized treatment and disposal facility, labor and working conditions (including minimal labor influx, gender based violence and sexual exploitation), community health and safety (including workers' community interactions, movement of chemicals, health waste). The likely potential impacts associated with the Project activities can be managed and mitigated with the application of appropriate mitigation measures.

Note To view the Environmental and Social Risks and Impacts, please refer to the Concept Stage ESRS Document.

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APPROVAL

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