Project Information Document (PID)

Concept Stage | Date Prepared/Updated: 02-Aug-2019 | Report No: PIDC26437

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Parent Project ID (if any)	Project Name
Lesotho	P170278		Lesotho Nutrition and Health System Strengthening Project (P170278)
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
AFRICA	Sep 23, 2019	Nov 14, 2019	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	Kingdom of Lesotho	Ministry of Health	

Proposed Development Objective(s)

To increase utilization and quality of key nutrition and health services and strengthen institutional capacity for institutional reforms.

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	60.00
Total Financing	60.00
of which IBRD/IDA	60.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	60.00
IDA Credit	60.00

Environmental and Social Risk Classification	Concept Review Decision

Moderate	Track II-The review did authorize the preparation to continue

Other Decision (as needed)

B. Introduction and Context

Country Context

1. **Lesotho reports high poverty levels and low human capital outcomes and is highly vulnerable to food insecurity and climate change.** Lesotho is a small, landlocked, lower-middle-income country with a 2017 per capita Gross National Income of US$1,280 (in current US$).[1] It has a population of 2.1 million. Lesotho generates income mainly through the farm sector, and from exporting textiles, water, and diamonds. Its main trading partners are the United States and South Africa. Around 57 percent of the Basotho people live below the national poverty line.[2] Lesotho's human capital index[3] is 0.37, which is below the Southern African Development Community average of 0.43.[4] Lesotho is by large a food deficient country due to several reasons including frequent climate shocks i.e., recurrent droughts, dry spells and floods which result in chronic food insecurity, especially in rural areas.

2. **Lesotho's economic growth has remained sluggish in recent years and its economy faces risks**. Real GDP growth was 3.1 percent in 2017.[5] Economic risks are due to the sharp declines in Southern African Customs Union (SACU) revenues, uncertainty of the Africa Growth and Opportunity Act renewal, inflation due to drought-induced higher food prices, and South Africa's declining growth. These risks are exacerbated by other vulnerabilities such as Lesotho's high HIV/AIDS, TB, maternal and infant mortality, and stunting rates; as well as climatic vulnerability (El Niño).

3. **The Government's long-term strategy as outlined in its 2018-2023 National Development Strategic Plan (NSDP II) is to promote inclusive growth through private sector-led jobs and reduced unemployment**. One of the NSDP's key pillars is to strengthen human capital: health and nutrition, education and skills development. It also recognizes the need to address food and nutrition security.

Sectoral and Institutional Context

4. **Health and nutrition outcomes in Lesotho have improved over time but remain low relative to level of government spending.** Lesotho's public expenditures on health reached 8.1 percent of GDP in 2014 -- almost four times the Sub-Saharan Africa average of 2.3 percent. However, its maternal mortality ratio (MMR) based on national estimates

[1] World Bank National Accounts Data.
[2] Household Budget Survey for 2010/11.
[3] The World Bank Group's (WBG) recently launched Human Capital Index measures the amount of human capital that a child born today can expect to attain by age 18, given the risks of poor health and poor education that prevail in the country where s/he lives.
[4] SADC is a regional organization comprised of 14 member countries.
[5] The African Development Bank, African Economic Outlook, 2018.

is still very high.[6] Even with modeled MMR estimates which tend to be much lower than national estimates, Lesotho's MMR (513) is higher than the averages for comparators (Table 1). While infant mortality decreased, it is still higher than comparator averages. Although stunting[7] decreased from 39 percent in 2009, 33 percent of 0 to 5-year-old children were stunted in 2014 which is still very high.[8] It is higher than stunting rates in Eswatini (25%) and Zimbabwe (27.6) but lower than averages for LMICs (33.6%) and SSA (35.7%). Malnutrition was the top cause of deaths among children in Lesotho.[9]

Table 1. Mortality and Stunting Rates in Lesotho relative to Averages in Lower Middle-Income Countries, Southern Africa and Sub-Saharan Africa

Indicator	Lesotho	Lower Middle-Income Countries Average	Southern Africa Sub-region Average	Sub-Saharan Africa Average
Neonatal mortality per 1,000 live births	34*	25.4	23	29.1
Infant mortality per 1,000 live births	59*	39.4	42	56.7
Under-five mortality per 1,000 live births	85*	52.4	57	84.7
Maternal Mortality Ratio maternal deaths per 100,000 live births (Modeled Estimate)	513**	262	310	560
Stunting (low height for age) children under five	33*	33.8	N/A***	35.7

Sources: World Development Indicators; *Lesotho Demographic and Health Survey 2014;
Lesotho's MMR based on the National Demographic Survey is 1,024 in 2014; * data only available for Eswatini, Lesotho, and Zimbabwe

5. **Lesotho´s relatively poor health and nutrition outcomes are in part the result of inadequate quality of primary care and essential hospital services.** In 2014 (latest nationally available information), 95 percent of 15-49-year-old women in Lesotho had one antenatal care (ANC) visit, 74 percent received four or more ANC visits, 77 percent gave birth in health facilities and 72 percent received post-natal care. Despite the high coverage of maternal services, Lesotho's high MMR suggests quality of care issues. A 2015 assessment found that only 6 out of 20 secondary hospitals in the country (where nearly half of institutional deliveries occur) provided Comprehensive Emergency Obstetric and Newborn Care certification (CeMONC) services to ensure safe delivery, and 89 percent of maternal deaths occurred in health facilities without CeMONC certification.[10] Studies note staff and supply shortages in health centers and a general negative public perception of health service quality in health facilities.[11] This perception is reflected in the low average bed occupancy rates (BORs) of 32 percent in district hospitals. At the same time, in-patient admissions at the Queen 'Mamohato Memorial (QMMH) referral hospital have been growing with cases of relatively low complexity, resulting in a higher average BOR of 74 percent since 2016.

[6] National estimates from Demographic and Health Surveys 2009 and 2014 are 1,155 and 1,024 out of 100,000 live births, respectively.
[7] Stunting is higher in rural and urban areas of the country (36% vs 28%) and, among children 02-23 months, child stunting is 12.8 percent in the richest household compared to 35 percent among the poorest households.
[8] DHS 2009, 2014
[9] According to the Cost of Hunger Study in Africa (COHA) Lesotho 2016, over 19% of all child mortality is associated with undernutrition, 17.7% of all repetitions in schools is associated with stunting, and stunted children achieve 3.6 years less in school. Child mortality associated with undernutrition, has reduced Lesotho's work force by 7.2%; and an estimated 45% adult population suffered from stunting as children.
[10] EmONC Report, 2015.
[11] Lesotho PER 2017.

6. **Health system management and capacity issues persist and affect system performance.** Several policies and strategic guidelines in the health sector have remained in draft form for almost a decade, limiting their actual enforcement. There is no health financing policy that defines co-payments for elective procedures and for privately insured patients, hospitals financing, a hard-budget constraint to providers and performance adjustment for care. The basic benefit package financed by the government is not defined. As a result, the government is invoiced for treatments at the QMMH and abroad that are usually excluded from a basic package (e.g. plastic surgery, fertility treatment, etc.). There is no treatment abroad policy that defines which treatments will be contracted abroad by the government, at what price and for which patients. Yet government spends more on treatment abroad. Referral guidelines to refer patients to the QMMH hospital, and from QMMH to lower-level providers are not enforced This contributes to very high utilization and occupancy rates at the QMMH. The absence of a village health worker policy has resulted in a large cadre of village health workers with unstandardized profiles and tasks that tend to be based on priorities of donors.

7. **Performance based financing (PBF) in the health sector has contributed to emphasize improving service quality, but capacity issues remain.** With the support of the soon to close Bank health project, the Government has been implementing a PBF approach in primary health centers (HCs) and district hospitals which was progressively scaled up to all 10 districts in July 2018. PBF has yielded some positive results. Data from the QMMH referral hospital show fewer facility-based maternal deaths due to maternity-related conditions referrals from PBF-enrolled district hospitals (63%) against non-PBF-enrolled hospitals (88%), suggesting better management of maternal care in PBF-enrolled hospitals. Nevertheless, PBF impact has been limited by (a) budget and management issues resulting in shortages of supplies; and (b) inadequate human resources for health (HRH) capacity and equipment. While 138 out of 145 health facilities have been refurbished and equipped by the Millennium Challenge Corporation,[12] there are still equipment gaps reported in regional and district hospitals.

8. **Inadequate capacity for monitoring and evaluation for evidence-based decisions also limit the envisaged benefits of PBF and PPP arrangements**. Although the QMMH sends quarterly reports on healthcare performance to the MOH, these reports have not been used by the MOH to manage care and health expenditures. Regular analysis would allow the MOH to identify inefficiencies and underfunding at different level of care. It would also help the MOH to predict when the QMMH will be surpassing the agreed quantity ceilings and enforce policies to manage care in the public and private sector.

9. **High levels of adolescent fertility contribute to high maternal mortality and child stunting**. Pregnancy among 15 to 19-year-old girls remained high at 20 percent in 2009 and 19 percent in 2014. These are high-risk pregnancies that are more likely to cause delivery complications and low birth weight which increases the risk for child stunting. Child stunting in Lesotho was higher among children born to adolescent mothers (38.6%), and highest among mothers without any education (58.1%) compared to those with secondary education (29.2%). However, Lesotho's net secondary school enrollment rate was only 37 percent: 45 percent for girls and 27 percent for boys. Limited access to reproductive health services for young women contributes to teenage pregnancy: among 15 to 19-year-old currently married women, only 55 percent had their needs for family planning satisfied in 2014.[13]

10. **Inadequate care and feeding practices, lack of dietary diversity, and environmental health all contribute to high stunting rates**. The 2015 Conceptual Framework for Child Malnutrition developed by UNICEF emphasizes childcare

[12] A United States Government financed infrastructure program targeting health, education and water.
[13] DHS 2014.

practices, dietary quality, psycho-social stimulation, access to water, and adequate sanitation and health care to prevent malnutrition. **Although** exclusive breastfeeding is recommended for 0 to 6 month old infants, it declines from 81.8 percent for 1 month old infants to 44 percent (4-5 month old infants) in Lesotho. By 6-8 months, 83 percent of children 6-23 months in Lesotho receive complementary foods along with breastmilk. However, in 2014, only 23 percent of 12-23-month-old children had diets with minimum dietary diversity, 61 percent had minimum meal frequency, and 11 percent had the minimum acceptable diet. Only 40.5 percent of children 6-23 months consume iron rich foods and only 60.5 percent consume vitamin A rich foods. As a result, anaemia prevalence is high at 51 percent and vitamin A deficiency is almost 33 percent. DHS data showed that stunting is significantly lower when a child is fed a minimal acceptable diet. Prevalence of diarrhea and enteric infection is common among children with poor feeding practices and inadequate access to water, sanitation and hygiene facilities. Children with prolonged exposure to unsanitary environments develop *environmental enteric dysfunction* (EED), a major cause of stunting. EED inhibits absorption and retention of essential nutrients.

11. **Lesotho has limited coverage of a combined package of nutrition specific and sensitive services in part due to limited capacity, coordination and funding across participating ministries/agencies at central and community levels.** Only 9 percent of children have simultaneous access to adequate health care, WASH and nutrition services.[14] While there are a large cadre of health, agriculture, social protection and education sector service providers present in districts and communities, recent assessments indicate insufficient implementation capacity, lack of clarity and overlapping roles and responsibilities of community-level program staff in service delivery. The Ministry of Health (MOH) and Ministry of Agriculture and Food Security (MOAFS) have a separate national budget line to cover nutrition services. However, a large amount of this funding is reported to be reallocated into other mainstream activities of the Ministries leaving the nutrition program inadequately funded. As a result, the nutrition program in Lesotho tends to be donor reliant leading to many intermittent programs.

12. **The Government of Lesotho is committed to advance nutrition and health and related reforms.** 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 regional and 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, Lesotho pledged to accelerate efforts to address child malnutrition to achieve SDG 2.2 target on ending malnutrition. In terms of policies and strategies, the Government's 2018-2023 National Strategic Development Plan II has a strategic 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 (i) National Nutrition Policy (2016) provides strategic guidance to sectors on a comprehensive approach to address malnutrition using evidence-based strategies; (ii) 2018 Zero Hunger Strategic Review (ZHSR) provides policy and strategic frameworks to increase food and nutrition security; (iii) Lesotho Nutrition Improvement Design Framework (2017) focuses on stakeholder roles, possible contributions and industry/sector specific value propositions; and (iv) National Food and Nutrition Strategy and Costed Action Plan 2018-2022 aims to reduce child stunting through a multisectoral approach and improve governance for nutrition. The National Health Sector Strategic Plan seeks to ensure equity and access to good quality health services at all levels of care. The MOH recently drafted a Village Health Worker policy to standardize their responsibilities oversight arrangements; all partners are expected to align their support to this

[14] Multisectoral Nutrition Needs and Gaps Analysis, MNAGA report. World Bank Advisory and Analytical services report, December 2018

policy which is expected to be approved by Cabinet by August 2019. The MOH also expressed its wish to continue with a simplified PBF program that could be sustained by Government resources.

13. **In addition, the Ministry of Education and Training (MOET) has an Early Childhood Care and Development (ECCD) Policy which promotes early stimulation, infant and young child feeding and, for preschool children, early school enrolment and learning.** The Government aims to provide access to quality ECCD and pre-primary education to all children so that they are ready for primary education. So far 16 ECCD centers of about 1,200 have been accredited by the MOET.

14. **Implementing these reforms would require strengthening the service delivery response and coordination at central and local levels**. The overall health system requires strengthening to ensure essential health services and nutrition-specific interventions are provided. Complementary interventions in agriculture; education; water, sanitation and hygiene (WASH); and social protection (SP) will help increase demand and promote adoption of healthy behaviors. Co-location of services to the extent possible would be key given that a 2018 analysis[15] estimated that access to a package of services (adequate health services, food and care, and WASH) would reduce the likelihood of stunting by roughly 33 percent in Lesotho**.** The well-recognized limited capacity of the Food Nutrition Coordination Office (FNCO) to oversee multisectoral coordination and participating ministries would need to be strengthened. Mapping and enhancing capacity of existing community platforms such as agricultural nutrition clubs and mobilizing key community actors would be essential to have a well-coordinated response at central and local levels that mutually enforce each other.

15. **To leverage Bank resources and maximize their impact, the project would be implemented in coordination with existing or soon to be approved World Bank projects**. To the extent possible, project interventions will be coordinated with those being implemented in the following participating sectors: agriculture (Second Phase Smallholder Agricultural Development Project), education (Lesotho Education Quality for Equality Project), social protection (Social Assistance Project), and WASH (Lesotho Lowlands Water Development Project II). In addition, proposed health system strengthening activities related to PBF institutionalization and PPP contract management will be coordinated with the Public Sector Modernization Project.

16. **Project design and implementation will also be coordinated with development partners to strategically fill in financing and coverage gaps for priority interventions.** There are several development partners supporting health and nutrition. While geographic coverage of donor-supported interventions covers all districts, population coverage only exceeds 75 percent for four out of 12 interventions with available population coverage information. The United Nations agencies support for multisectoral interventions focus mainly on 1-2 districts, technical assistance to the government and capacity building for master trainers on nutrition. There is no funding available for implementation, coordination or monitoring support at the sub-national level. To address coverage gaps of selected key interventions, the proposed project will support a package of coordinated interventions. It aims to address health service delivery gaps by supporting the delivery of essential health and nutrition services, strengthening the quality of care and M&E capacity through performance-based financing, and training of medical personnel; address WASH gaps by leveraging funds for low-cost handwashing stations to improve hygiene; address nutrition and food security gaps by piloting farm to table activities (e.g., vegetable gardens) in ECCD centers and for centers for neglected and orphaned children, financing small community-based grants to improve nutrition and strengthen social protection mechanisms, and mobilization of nutrition outreach interventions/trainings between extension workers from participating ministries (e.g. village health workers, agricultural

[15] All Hands on Deck: Reducing Stunting Through a Multi-Sectoral Approach in Sub-Saharan Africa**.** 2018

technical officers) and communities through local platforms. To bridge the gap in coordination support at the sub-national level, the project will support the institutional capacity strengthening of the FNCO, especially with the development of a common multisectoral nutrition work plan that leverages local platforms and a nutrition information system that encompass central to local levels.

Relationship to CPF

17. **The proposed multisector project is aligned with the Lesotho Country Partnership Framework (CPF) 2016-2020 in the following aspects**:

a. **Project design is linked to the CPF's first pillar on improving efficiency and effectiveness of the public sector.** Lesotho's authorities believe that fragmentation of government institutions contribute to inefficient administration which needs to be addressed through stronger internal policy coordination. The proposed activities will support coordination in the management and delivery of key health and nutrition services, by minimizing duplication and enhancing synergies across sectors from central to local levels. The project will continue to support health system strengthening to improve both quality and efficiency of public spending on health including through policy formulation and implementation. The project will provide technical assistance to policies and strategies such as the health financing strategy, a patients' referral system and defining the basic benefit package to be funded by the government. The project will also support the Food and Nutrition Coordination Office in its coordination role to bring together sectors and partners working in nutrition. In addition, the project will establish a multisectoral nutrition information system (based on routine monitoring systems of relevant sectoral ministries) to enhance said coordination. To document improved efficiency and effectiveness of the public sector, the project will strengthen M&E capacity at the MOH and support relevant data collection and analysis.

b. **The project design has incorporated the lessons learnt from the mid-term program learning review of the CPF.** These lessons include paying attention to capacity constraints, and pro-actively addressing knowledge needs. Accordingly, the Project will support the design and implementation of a simpler and less expensive PBF program that is aligned with the Government's capacity, fiscal resources and systems. It will contribute to institutional strengthening, for example, by enhancing medical equipment and supplies management. It will also finance selected studies such as the National Nutrition Survey to gather local evidence on nutritional adequacy of diets, socio- economic and cultural factors that influence eating patterns and nutrition status of the population

c. **The Project is aligned with the CPF recommendation to consider the recurrence and high risk of climate-related shocks in Lesotho**. It includes a Contingency Emergency Response Component in the project design.

C. Proposed Development Objective(s)

18. Increase utilization and quality of key nutrition and health services and strengthen institutional capacity to implement key policy reforms in the health sector.

Key Results (From PCN)

Utilization and quality of nutrition services

a. Percentage of pregnant women receiving iron and folic acid supplementation (nutrition specific, utilization)
b. Percentage of women age 15-19 currently using modern contraceptive method (nutrition sensitive, utilization)
c. Percentage of children 6-23 months with minimum recommended dietary diversity (nutrition sensitive, quality and

utilization)

Quality of health service delivery

a. Percentage of health facilities attaining the first star level in the star quality rating system
b. % of partogram documentation in maternity department in compliance with quality requirements

Institutional Capacity for selected health reforms

a. Health financing policy adopted, and implementation initiated
b. Defined health services benefit package that considers Lesotho's disease burden and fiscal constraints adopted

D. Concept Description

19. **The proposed US$60 million IDA-financed project aims to support the Government of Lesotho (GOL) in implementing a multisectoral approach to improve health and nutrition outcomes over a five-year period**. The project will strengthen the overall health system by emphasizing allocative efficiency across levels of care, financial sustainability, and an evidence-based focus on results. It will finance the implementation of a coordinated package of selected health and nutrition interventions involving the Ministries of Agriculture; Education and Training; Health; Water, Sanitation and Hygiene (WASH); and Social Protection (SP) and the Food and Nutrition Coordination Office (FNCO). Nutrition interventions will prioritize the first 1,000 days of life (pregnancy and the first years of a child) when low cost interventions have been proven to have the most impact. Adolescent girls will be strategically targeted given the high rate of teenage pregnancy and its related risks to the health of young mothers and their infants.

20. T**he multisectoral coordinated approach will be strengthened at the central level and in communities**. It will strengthen institutional coordination, and selected nutrition-related interventions provided in health centers, ECCD centers, and in SP child care centers. This facility-based support will be complemented with community-based interventions such as outreach activities by extension workers in agriculture, and existing community-based platforms (e.g. youth groups, women's groups) to maximize impact at the local level.

21. Most interventions will be implemented nationwide. Implementation will be phased based on criteria to be agreed with Government. A main consideration would be feasibility and ease of co-locating key multisectoral interventions to maximize impact.

1. Description

The proposed Project will have four main components.

Component 1. Providing Multisectoral Services to Address Chronic Malnutrition (US$25 million)

22. This component will have four sub-components:

23. **Sub-component 1.1. National Nutrition Communication Strategy**. The government has developed a Multisectoral National Nutrition Communication Strategy (MNNCS) that will be coordinated by the FNCO. The proposed project will finance TA to the FNCO to support the development and implementation of the MNCCS workplan. Activities will include: (i) awareness generation on child stunting, and advocacy with parliamentarians and decision makers on critical issues; (ii) development of sectoral communication strategy; (iii) dissemination of multisectoral nutrition messages through the mass

media; (iv) social and behavior change communication (SBCC) at the community level; and (v) use of traditional media and other innovative platforms.

24. **Sub-component 1.2. Community-based initiatives to address multisectoral determinants of chronic malnutrition**. The sub-component will support mapping and strengthening of existing community platforms (such as water and health women groups, youth and adolescent groups, and agriculture nutrition clubs). These groups will be linked with community-based service providers (such as agricultural extension workers, environmental health workers, and village health workers) who will sensitize and train them. This sub-component proposes to provide TA to support the development and implementation of a comprehensive and sustainable community-based nutrition program for Lesotho, which will be coordinated by the FNCO. TA will help in developing a workplan so that the communities will be able to adapt and sustain healthy behavior. It will provide TA, counseling, and small grants to community initiatives such as youth groups, etc. to implement the workplan and contribute to strengthening (a) nutrition outreach interventions by health facilities in communities and (b) cooperation across extension services provided by community-based workers mapped to the Ministries of Health, Agriculture, WASH, and Social Development. The community grants are to help improve household food and nutrition security to increase food production and livelihoods through small-scale food processing, raising livestock such as chickens and small ruminants. Grant implementation guidelines will be detailed in the Project Implementation Manual.

25. **Sub-component 1.3 Nutrition sensitive services in Early Childhood Care and Development (ECCD) centers and Child Care Centers.** This sub-component will finance TA and supplies to the ECCD centers who pass the compliance and risk assessment to be conducted by the MOET in collaboration with the World Bank; and to 24 child care centers for neglected children and orphans. It proposes to (a) sensitize and train staff, caregivers and teachers in ECCD and child care centers on malnutrition (to be coordinated with the health sector); (b) pilot a “farm to school feeding program” for ECCD centers in selected districts (criteria to be proposed for selection of districts) and design and implement a sustainable nutrition program for 24 childcare centers in coordination with the Agriculture sector; (c) explore in coordination with other development partners and community based organizations supporting the establishment of low-cost handwashing stations (water containers and soaps) in ECCD schools and child care centers. and (d) strengthen implementation of school health programs (e.g. deworming) in coordination with the MOH in ECCD centers.

26. **Sub-component 1.4. Adolescent school health.** This sub-component will provide TA and supplies to strengthen the existing school health program at the MOE and MOH. The goal is to keep adolescents healthy, prevent early pregnancy and contribute to school retention. Support will include TA to counseling services, group education, peer-to-peer mentoring, as well as dispensers for hygiene products and contraceptives in toilets, and supervised iron and folic acid supplementation and provision of de-worming tablets in selected secondary schools that will be coordinated with the existing WB education project.

Component 2: Strengthening Health Systems (US$29.5 million)

This component proposes to finance interventions to increase the focus on results, particularly in enhancing the quality and efficiency of health service delivery. It will finance activities to strengthen health sector governance and capacity building for the health workforce. It will be composed of three main sub-components:

Sub-Component 2.1. Focus on Results

27. **Sub-component 2.1.1. Second-Generation Performance Based Financing.** This component will finance grants to health facilities, TA for monitoring and evaluation (M&E) and operational expenses to implement a simplified second generation PBF model in the health sector. A quality grant will be provided to enrolled health facilities for the provision of a package of quality maternal and high impact nutrition interventions. These interventions include (1) promotion of maternal and children nutrition and hygiene practices, focused on the first 1,000 days; (ii) micronutrient supplementation for children and (iii) essential nutrition and health interventions for women such as iron and folic acid supplementation, antenatal care, postnatal care, nutrition counseling and family planning). Quality grants will be supported by TA to design and implement quality learning modules for health staff (part of continuous medical education). The training modules will cover Maternal, Newborn, and Child Health, Communicable and Non-Communicable Diseases, Emergency Care, and Nutrition services. The project will also finance TA for M&E to measure and evaluate relevant performance indicators, as well as operational expenses related to M&E and supervision.

28. **The project proposes to support PBF institutionalization using a phased approach**. The proposed institutionalization plan would entail several changes including integrating the PBF scheme into the health financing policy. The project will finance TA to strengthen Public Financial Management (PFM) in health facilities; health information system, and coordination between the MOF and the health sector (see next sub-component).

29. **Sub-Component 2.1.2: Disbursement-Linked Indicators (DLI) for health system reforms.** In line with the Government's interest to improve the focus on results in the health sector, the project proposes to motivate the adoption of key policies and actions through aa DLI-financing mechanism. DLIs be will selected among the following:

a. Referral guidelines to all health care providers including for treatment abroad adopted and disseminated
b. Defined health services benefit package that considers Lesotho's disease burden and fiscal constraints adopted
c. Health financing policy adopted, and implementation initiated
d. Pharmaceutical policy adopted
e. PBF scheme institutionalized in Government system as evidenced by (a) the modification of chart of accounts to reflect PBF; (b) the creation of a PBF budget line item; (c) successful disbursement of funds to PBF contracted entities, and (d) transition to Integrated Financial Management Information System (IFMIS) at the MOF for the development budget.

Sub-component 2.2. Quality of Care

30. **This sub-component will enhance quality of care through better health management, medical equipment and stock management**. The project will finance TA to support the design of a comprehensive national strategic plan to improve quality of care and strengthen M&E capacity. The Quality of Care Strategic Plan would establish a facility quality certification system (e.g. "star rating" as they are known in many other SSA countries) and pilot it in Maseru. Project support will include: (i) TA to conduct an equipment gap assessment in hospitals using the WHO checklist for basic equipment for maternal and child health care and the treatment of most common diseases; (ii) procurement of basic equipment identified in the gap assessment as well as family planning commodities and micronutrient supplements; (iii) TA to assess bottlenecks and constraints in procurement and last mile delivery system(s) to strengthen pharmaceutical management and ensure sufficient stocks of essential medicines in hospitals and health centers; (iv) training and capacity building of health staff and management in selected hospitals on the use of the new equipment and to strengthen quality and management of care.

31. **It will also finance capacity building, particularly support to the National Health Training Center (NHTC), trainings for doctors, nursing students and VHWs on key health and nutrition interventions**. This sub-component will

support health workers to receive pre- and in-service training on key interventions supported by the project such as infant and young child feeding, timely detection of high-risk pregnancy cases during check-ups for referral to hospitals, etc. The project will finance TA to strengthen the NHTC's capacity to train and to engage in the quality of care improvement mentorship program. The project will provide TA to strengthen the MOH's Quality Assurance Unit's capacity for quality assessment of health care. The project will support different types of training and assessment modalities including e-learning platforms and digital HRH evaluation tools.

Sub-component 2.3. Technical Support and Capacity Building on Health Policy, Health Financing, Performance-Based Financing Institutionalization, and Public Private Partnerships

32. **The project will finance technical assistance to the MOH. Areas of technical support will include:**

(a) developing and implementing relevant health and nutrition policies and strategies to ensure efficient delivery of quality care within a fiscally constrained setting. These include: the basic benefit package that will be financed by the government at different levels of care; a referral policy across levels of care and for treatment abroad; a health financing policy; and a pharmaceutical strategy.

(b) health financing analyses. These will include institutionalization of National Health Accounts at MOH, and analysis of the severity case-mix of patients treated in hospitals based on existing 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) data to inform future hospital payment.[16]

(c) Support and adoption of a Health Financing Coordination mechanism

33. **The project will strengthen health sector monitoring, evaluation and learning system**. Interventions would include TA to the MOH and health facilities for improving the Health Management Information System routine data collection and analysis. It will include better monitoring and developing necessary interventions to address potential impacts of climate hazards. It will also build MOH analytical capacity to regularly analyze hospital performance including of Queen 'Mamohato Memorial Hospital (QMMH) reports on healthcare performance. It will contribute to ensuring that MOH uses the results to manage health care and health expenditures.

34. **Component 3. Project Management, Multi-stakeholder Coordination, Program Monitoring, Evaluation and Learning ($5 million).** The primary objectives of this component are to enhance national capacities for coordination and governance on nutrition and to strengthen project management. It will have three main sub-components:

a. **Sub-component 3. 1. Overall Nutrition Advocacy, Co-ordination, Monitoring and reporting to Prime Minister's office.** This subcomponent will support institutional capacity development of the Food Nutrition Coordination Office (FNCO) to: (a) conduct multisectoral advocacy for nutrition; (b) coordinate with Ministries of Agriculture and Food Security, Water, Health, Education and Training and Social Development to develop a common multisectoral nutrition plan along with sectoral targets at the national and subnational level; and (c) establish a multisectoral nutrition information system (based on routine monitoring systems of sectoral ministries), to monitor and track project progress at the national and local level.

b. **Sub-component 3.2. Project Management**. This sub-component will finance day to day management of project activities by the Project Implementing Unit[17] that is housed in the MOH. The PIU will coordinate with

[16] The ICD-10 is a medical classification of the WHO. It contains codes for diseases, signs of symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases.

[17] The capacity of the current PIU for the Regional TB and Health system Strengthening Project will be strengthened to enable it to effectively oversee this new project.

the FNCO and participating ministries to plan and implement project activities, and track progress through project monitoring data, progress reports, audits and other assessments. .

c. **Sub-component 3.3. Assessments, Knowledge Sharing and Learning**. The project will finance data collection and studies such as a national nutrition survey and an evaluation of the PBF program. It will also finance assessments of pilot programs such as the ECCD farm to school feeding program, as well as periodic joint stock-taking of progress made in project interventions to facilitate knowledge and experience sharing and allow for timely adjustments during project implementation.

35. **Component 4. Contingency Emergency Response Component/CERC** (US$0.5 million). In the event of an Eligible Crisis or Emergency, the project will contribute to providing immediate and effective response to said Eligible Crisis or Emergency. To help speed up the response, the project proposes to allocate an amount to reduce time spent on assessing which activities to cut and reallocate funds from. Any unused amount would be reallocated to other components if the CERC component is not triggered a year prior to project closing.

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

Summary of Screening of Environmental and Social Risks and Impacts

The proposed Project is expected to have generally positive environmental impacts and components are not anticipated to result in any substantial or irreversible impacts as the project will not support any construction activities. However, it is anticipated that activities under Component 2 to support the strengthening of health Systems will result in the increase of health services utilization which will, in turn, lead to marginal increases in the generation, handling and disposal of health care waste streams. Related environmental risks would be expected related to the inappropriate and unsafe handling, transportation, treatment and disposal of hazardous medical waste, including infectious waste; pharmaceutical waste; chemical waste; and sharps. Potential impacts are expected to be site specific, reversible and managed through established and proven mitigation measures.

Furthermore, the project footprint is small with limited and manageable adverse social impacts that can be mitigated and managed with the application of appropriate mitigation measures. Project activities under Component 1 will be implemented in land already owned by benefiting public institutions as project beneficiaries (e.g. schools, clinics, hospital, ECCD centers, etc.) and will not be eligible should they induce land acquisition or adversely affect or restrict livelihoods. The project is likely to have limited requirement of labor and the kitchen gardens will be supported by local farmers. The social rating takes into account the limited capacity of the MOH and the PIU at both national, district and community levels in the application of the ESF and applicable Standards.

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

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