Public Disclosure Authorized

Project Information Document (PID)

Appraisal Stage | Date Prepared/Updated: 07-May-2021 | Report No: PIDA29305

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BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Project Name	Parent Project ID (if any)
Somalia	P172031	Improving Healthcare Services in Somalia Project (“Damal Caafimaad”)	
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
AFRICA EAST	22-Mar-2021	29-Jun-2021	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	Federal Ministry of Finance	Federal Ministry of Health	

Proposed Development Objective(s)

The Project Development Objective (PDO) is to improve the coverage of essential health and nutrition services in project areas and strengthen stewardship capacity of Ministries of Health.

Components

Component 1: Expanding the coverage of high-impact health and nutrition services in select geographic areas
Component 2: Strengthening Government’s stewardship to enhance service delivery
Component 3: Project Management and Knowledge Management and Learning
Component 4: Contingency Emergency Response Component (CERC)
Project Activities in Somaliland (Details TBD)

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	100.00
Total Financing	100.00
of which IBRD/IDA	75.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	75.00
IDA Grant	75.00
Non-World Bank Group Financing	
Trust Funds	25.00
Global Financing Facility	25.00

Environmental and Social Risk Classification

Substantial

Decision

The review did authorize the team to appraise and negotiate

B. Introduction and Context

Country Context

1. **Somalia has experienced prolonged conflict beginning with the ouster of the Siad Barre regime in 1991 and is among the poorest countries in the world, with a per capita Gross Domestic Product (GDP, nominal) of US$ $335 in 2020**.[1] An estimated 69 percent of the Somali population live in poverty (below US$1.90 per day, 2018 estimate).[2] While there is no recent census data, Somalia's total population is estimated to be 15.4 million.[3] Substantial population growth, compounded by a high fertility rate of 6.9 births per woman (2019)[4] has resulted in a young population, with 66 percent of the population under 19 years of age.[5] Youth unemployment is high and educational attainment limited, with only 16 percent of the population completing primary school and 7 percent completing secondary school.[6] Gender disparities in Somalia are also among the worst in the world, characterized by limited access to formal education, high rates of gender-based violence (GBV), as well as a nearly universal prevalence of 99.2 percent for female genital mutilation (FGM). The impacts on human capital, as well as health and well-being, are severe and present a significant barrier to development.

2. **Somalia is transitioning towards increased stability through institutional and political reforms, which began with the adoption of a provisional constitution and a Federal Government in 2012.** The federal system established under the 2012 provisional constitution carved out four new Federal Member States (FMS), resulting in a total of six states under the Federal Government of Somalia (FGS).[7] In the transition to greater political stability, the Government has improved financial transparency and institutional structures through the adoption of reforms and improved governance. In March 2020, Somalia achieved the HIPC milestone, reopening access to regular concessional financing from the International Development Association (IDA) and other International

[1] World Economic Outlook, 2020.
[2] Somalia Economic Update, 2020.
[3] United Nations, Department of Economic and Social Affairs, Population Division (2019). World Population Prospects 2019
[4] SHDS, 2020
[5] Somalia Health and Demographic Survey (SHDS), 2020
[6] Somalia CPF, 2018
[7] New FMS are: Galmudug, Hirshabelle, Jubbaland, and South-West State (SWS). Existing areas that became States include: Puntland and Somaliland (the latter considers itself independent from Somalia, but is not recognized as such).

Financing Institutions, along with investments in private capital, including those from the International Finance Corporation (IFC). However, an active armed insurgency, unresolved constitutional issues, weak service delivery capacity, fiscal capacity constraints, and continual humanitarian crises remain. Somaliland, with a population of approximately 3.5 million, declared independence from Somalia following the 1991 Somali Civil War. Somaliland's relationship with the FGS remains politically complex.

3. **Somalia's recurrent natural disasters, conflict, and associated disruptions of economic activity hamper development efforts.** The country faced the impact of crippling droughts from 2016 to 2017 and again in 2019, together with protracted and ongoing armed conflicts, resulting in the internal displacement of more than 2.6 million people and widespread hunger. Cyclical floods and droughts are increasingly common features and their co-existence poses a substantial hazard. With most Somalis dependent on agriculture (primarily livestock) and forestry, continued climate and conflict challenges destabilize daily life. The interlinkages between climate and environmental change, cyclical drought, poverty, fragility, severe food insecurity, and protracted conflict are arguably more pronounced in Somalia than in most countries. In late 2019 and 2020, the country faced severe floods and a desert locust infestation. Somalia's annual economic growth rate was approximately 2.8 percent between 2016 and 2020, but due to the COVID-19 pandemic and associated economic disruptions, the economy is estimated to have contracted by 1.5 percent in 2020. The economy is highly dependent on foreign remittances, which are estimated to make up 31.2 percent of the country's GDP (2020), with less access to remittances among rural and poor populations. Fiscal capacity remains low, with a government expenditure to GDP ratio of 12.4 percent (2020), underlined by nascent tax mobilization systems with a tax-to-GDP ratio of 2.5 percent (2020), which further constrains service delivery.[8]

Sectoral and Institutional Context

4. **Somalia's lagging health outcomes reflect the country's insecurity, vulnerability, and deep-rooted poverty, limiting access to basic social services, including education and health.** Somalia's health indicators remain among the worst in the world, with an average life expectancy of 56 years. Service delivery indicators are low nationwide and estimated at 0.23 outpatient visits per person per year and 0.81 hospital discharges per one hundred people per year (SARA, 2016). Due to a combination of health service supply and demand challenges, only 32 percent of births are attended by skilled personnel, 31 percent of women receive at least one antenatal care (ANC) visit nationwide, and only 11 percent of children are fully immunized nationally.[9] The 2009 Essential Package of Health Services (EPHS)[10], which started implementation in 2013, does not reach the entire population. According to 2017 WHO figures, approximately 47 out of 89 districts (5.7 million people) were covered by part of the EPHS, representing 41 percent of the population. However, following the closure of the JHNP after the end of UK Foreign, Commonwealth and Development Office's (FCDO; previously DFID) financing, the previously coordinated EPHS implementation became fragmented, with partial geographic coverage and varying package components supported by different funding partners. In additional, there are gaps in essential inputs including health workers, essential medicines, and medical equipment, particularly in public facilities. The availability of

[8] World Bank, (2020). Somalia Economic Update, June 2020: Impact of COVID-19-Policies to Manage the Crisis and Strengthen Economic Recovery

[9] SHDS, 2020; Skilled personnel: nurse, midwife, auxiliary midwife, clinical officer, or doctor.

[10] The 2009 EPHS is comprised of core and additional programs. The EPHS 2009 six core programs were: Maternal, reproductive and neonatal health; Child health; Communicable disease surveillance and control, including WASH promotion; First aid and care of critically ill and injured; Treatment of common illness; and HIV, STIs and TB. The four additional programs are: Management of chronic disease and other diseases, care of the elderly and palliative care; Mental health and mental disability; Dental health; and Eye health. Compared to the 2003 BPHS prepared in Afghanistan, the Somalia EPHS was much broader and subsequently required more resources to implement.

qualified medical staff is predictably concentrated in urban areas, with rural areas facing more pronounced recruitment and retention challenges. In addition, the spread of COVID-19 across Somalia has further constrained the already fragile health system, diverted limited available resources towards COVID-19.

5. **The private sector is an important health service provider, with at least 60 percent of health services and 70 percent of the country's medicines estimated to be delivered by the private sector**. However, it is also largely unregulated with many unqualified individuals believed to be providing health services, particularly in private facilities. Supply chain management for health is challenged by the volatile security environment, poor infrastructure, human resource shortages and low capacity, limited access to supervision and monitoring, and a lack of functional, integrated sector-wide information management systems. Additionally, socio-cultural factors, like clan structures and who has decision-making responsibility within the household, play a significant role in the health seeking behaviors and status of women in Somalia.

6. **Service delivery challenges are also underpinned by very limited financing for health in Somalia**. Real per capita expenditure on health is approximately US$13 per person per year (2019), far below Sub-Saharan Africa's average of US$204 (2019). Government expenditure on health as a percentage of per capita health expenditure is 15 percent (2019). Consequently, out-of-pocket payments (OOP) as a percentage of per capita health expenditure in Somalia are high at 46 percent. Average annual household OOP on health is estimated at US$6 per capita out of a total of US$13 (2019) and varies substantially between the richest quintile and the poorest quintile, indicating that households are accessing healthcare services based on the ability to pay instead of their healthcare needs, resulting in health inequities.[11] Donor financing is an important source of health expenditure, comprising 38 percent of per capita expenditure (2019) and much of this is off-treasury.[12] The high proportion of off-treasury donor resources has limited the Government's involvement in many aspects of health sector programming, constraining the ability to increase efficiency in spending and Government leadership in the sector.

7. **Somalia's FMoH is nascent and at the early stages of building capacity to manage health services, including contract management.** The Government's role in health service delivery is limited, with most services delivered by NGOs financed by partners. Approximately 25 percent of the FMoH's over 500 employees are civil servants; the remainder are donor financed and are primarily contracted on a short-term basis. Weak financial control systems were highlighted by an Auditor General's Office report, indicating governance challenges within the FMoH. The four emerging Federal Member States (FMS) which make up Somalia's former South Central Zone (Hirshabelle, Galmudug, South-West, and Jubbaland), have even more nascent ministerial structures and limited capacity, with few resources on-treasury, low budget execution rates, and few to no civil servants. These states are also highly dependent on partners to provide stewardship for service delivery, with varying degrees of health policies and procedures in place and implementation capacity. The current Government has demonstrated a commitment to anti-corruption, as evidenced by the passage of anti-corruption legislation in September 2019 and continues to work toward establishing transparent and credible government systems.

8. **Somalia became a Global Financing Facility (GFF) country in 2019, an important step towards reducing health sector fragmentation, improving partner alignment, and strengthening the Government's stewardship role, which will be further supported by the Project.** Somalia is currently developing an Investment Case (IC) to improve health outcomes by enhancing health service coverage and quality, developing Government stewardship

[11]Micah, A. E., Su, Y., Bachmeier, S. D., Chapin, A., Cogswell, I. E., Crosby, S. W., Moitra, M. (2020). Health sector spending and spending on HIV/AIDS, tuberculosis, and malaria, and development assistance for health: progress towards Sustainable Development Goal 3. *The Lancet*.

[12] Same as #11

capacity, and mapping resources available in the health sector to improve partner alignment and reduce health sector fragmentation.

C. Proposed Development Objective(s)

Development Objective(s) (From PAD)

9. The Project Development Objective (PDO) is to improve the coverage of essential health and nutrition services in project areas and strengthen stewardship capacity of Ministries of Health.

Key Results

10. The progress towards the above PDO will be assessed by the following set of PDO-level indicators as well as intermediate results indicators (IRIs) in the Project's Results Framework. To monitor progress in areas with World Bank supported service delivery, individual progress for each target region and population-weighted averages for all target regions and will be used:

- Percentage of births attended by skilled health personnel in a health facility (Component 1)
- Percentage of children between 6-59 months old receiving Vitamin A supplementation (Component 1)
- Percentage of children under one year of age receiving Pentavalent 3 (Component 1)
- Percentage of women of childbearing age using modern contraceptives (Component 1)
- Percentage of contracted service providers paid on time (within 45 days of receipt of reports and invoices) (Component 2)
- Percentage of Government health facilities that submit timely and complete HMIS reports by the 15th of the following month (Component 2)

D. Project Description

11. **The total proposed financing envelope for the Project is US$100 million (**US$75 million - IDA; US$25 million – GFF Trust Fund). The Project has four components: (1) Expanding the coverage of high-impact health and nutrition services in selected areas; (2) Strengthening MOHs stewardship to enhance service delivery; (3) Project management; and (4) Contingent Emergency Response Component (CERC). The Project will focus on expanding an essential package of high-impact health and nutrition services across the population in project target regions within available resources and service delivery capacity, and also aims to develop the MoH's capacity at the FGS and FMS levels to act as stewards of the health sector. Component 2 of the project will have national coverage. The Project will also contribute to supporting the Project's development objectives in Somaliland.

12. **Component 1 will finance delivery of select, high-impact health and nutrition services** with a focus on: (i) child health services (routine immunization, micronutrient supplementation, promotion of infant and child feeding and nutrition referral); (ii) maternal and neonatal health services, including testing and interventions during ANC visits, basic and comprehensive emergency obstetric and newborn care (BEmONC and CEmONC), and family planning; (iii) gender-based violence (GBV) services (awareness raising, case identification, counselling, and management); and (iv) disease surveillance (strengthening and maintaining disease surveillance and response as well as preparedness and response to disease outbreaks). These health services will be accompanied by health education and behavior change communications, as well as referral mechanisms to the appropriate level of service delivery. The select, high-impact health and nutrition services are anticipated to cover a total population of approximately 1.62 million in four or five target regions by Year 4. As part of Component 1, the Project will support third party monitoring (TPM) to assess project outcomes nationwide, regardless of program/ donor support.

13. **Component 2 will support development of government's stewardship capacities at both the Federal**

and FMS levels in the following technical areas: (1) health management information systems, data use, (2) public financial management (PFM)/ contract management/ health financing, (3) private sector development and regulatory reforms, and (4) organizational development. The HMIS and data use subcomponent aims to improve data timeliness, quality, and use of DHIS2 to contribute to the long-term goal of ensuring a high-functioning health information system producing regular, quality, reliable data that are used for routine decision making. The PFM, contract management and health financing subcomponent will build Government contracting capacity and strengthen efficient resource use and accountability to mitigate fiduciary risks. The private sector development and regulatory reform subcomponent will improve quality of health services delivered by the private sector through private sector networks, setting up basic regulatory and accreditation systems with a focus on the health workforce as well as health products and devices to improve quality of care. The organizational development subcomponent will support development of systems and process for decision making, internal information sharing, internal communication, external communication, and information storage/record keeping; and enhancing capacity for planning, learning and review including development and implementation of systems and processes for regular review and learning

14. **Component 3** will support day-to-day project management including coordination, administration, communication, management, procurement, M&E, and dissemination of project activities at both FGS and FMS levels. To this end, the component will finance the following activities: (i) supervising, coordinating, and providing oversight for project implementation facilitating, and (ii) learning and knowledge sharing across and within FGS, Somaliland and FMS.

15. **Component 4,** a zero cost component known as a Contingency Emergency Component (CERC), will provide immediate surge funding in the event of a public health emergency, such as a disease outbreak, is included if the need to reallocate funds arises. This component will only be triggered in the case of a public health emergency and when certain actions, as agreed by the Government and Bank teams, are met.

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

16. **The ESRS will be used iteratively as a design and appraisal tool from the initial stages of project preparation**: however, a final completed screening will be included as part of final project documentation. Pre-screening of the project documents will help ensure that social and environmental sustainability issues are considered and integrated into project design, enhancing the quality of the project. Early screening will help to anticipate how the relevant World Bank's environmental and social standards are best addressed in the project design.

17. **Screening of project activities (or sub-projects funded and implemented under this project) will be a desk-based exercise in which the project team**, including ES Safeguards specialists, will draw on their experience and professional judgment and, where warranted, on expert advice. Screening project activities or sub-projects with potentially significant social and environmental risks and/or impacts requires more time and

may need to involve relevant experts. While the screening process takes place during the project concept, design and preparation stages, implementation and monitoring of identified risk management and mitigation measures will be required of the PCIU throughout the life-cycle of the project.

18. **The summary of environmental risks at concept stage is as follows:**

i. Provision, storage, handling, and disposal of essential drugs, supplies and equipment will result in the generation of significant amount of medical and other hazardous waste (that is generally expected to be non-toxic and non-hazardous) on a daily basis as a result of delivery of preventive and curative health services;
ii. Possible exposure of health facility staff, waste handlers, patients and other facility users and the larger community to medical and other hazardous waste and associated ill health;
iii. Rehabilitation of health facilities may result in generation of debris and other solid waste;
iv. Inadequate incineration or the incineration of unsuitable materials may result in the release of pollutants into the air and in the generation of ash residue. In addition, incineration of heavy metals or materials with high metal content (in particular lead, mercury and cadmium) can lead to the spread of toxic metals in the environment; and
v. Disposal of untreated health care wastes in landfills can lead to the contamination of drinking, surface, and ground waters if those landfills are not properly constructed, posing danger to human health and community wellbeing.

19. **The summary of screening of social risks includes the provision that the project will not include acquisition of land/restriction of land use.** Rehabilitation of health facilities may result in potential risks related to labor and working conditions, such as work-related discrimination, GBV and OHS. Considering the contextual risks of operating in a conflict zone where effective and inclusive community consultations, stakeholder engagement and community participation and safety of staff is challenging, and the risk of project benefits not reaching the underserved populations including, nomads, other vulnerable and marginalized groups, internally displaced populations and developing effective grievance redress mechanism due to difficulty in accessing rural Somalia, the social risk rating is substantial. Ensuring health services are acceptable and accessible to women particularly when delivered by men and the potential risks of sexual exploitation and abuse or sexual harassment in delivery of uptake of health services is also a concern.

E. Implementation

Institutional and Implementation Arrangements

20. **Project Coordination and Implementation Unit (PCIU) at FGS-MoH**. Under the Project, a Project Coordination and Implementation Unit (PCIU) will be established as the responsible implementing entity in the FMoH. To ensure sufficient support to the Government to implement the project, given the nascent state of FMoH structures, the establishment of the PCIU is a condition of project effectiveness. In the long term, the PCIU aims to serve as a single coordination and management unit for development partner financing and activities in the FMoH, to support the Government's objective of increasing on-treasury resources and coordination. The PCIU will be responsible for overall project coordination, implementation, and day-to-day management and monitoring of the project. This includes: (i) ensuring project activities are implemented as agreed and in compliance with the World Bank technical and fiduciary guidelines; (ii) leading technical, operational, and fiduciary functions, especially contracting and contract management; and (iii) coordinating and overseeing project implementation/ management in the respective FMS/ Somaliland, including monitoring and evaluation of project activities, capacity

building, and ensuring compliance to social and environmental safeguard requirements. The PCIU will also prepare the annual work plan and budget for the Project, by no later than November 1st of each year, commencing on November 1, 2021.

21. **Project Management Team at FMS-MoH.** Each FMS will enter into a subsidiary agreement with the FGS to ensure project implementation and monitoring at the designated FMS-MoH level and secure the FGS-FMS collaboration under the Project. Each FMS will form a PMT at the FMS-MoH. The PMT will be primarily responsible for project management at FMS-level, including managing and tracking implementation progress, identifying opportunities for implementation improvements and solving day-to-day issues that may delay implementation. Key responsibilities of the PMT include reviewing project activity design, technically supporting implementation agencies, project M&E, and coordinating with the FMoH PCIU. Overall, the Project Manager in each PMT will coordinate efforts within their respective governments, across other World Bank-financed projects in the health sector, as well as between the FGS and the FMS.

22. **A Project Steering Committee will be formed and organized by the FMoH** to review the project's progress towards the PDO, discuss implementation challenges, and provide solutions/directions to move implementation forward on a quarterly basis, chaired by the Director General, FMoH. A Project Leadership Committee will also be organized bi-annually between FGS and FMS, chaired by the Federal Minister of Health, with participation by the FMS Ministers of Health. At the FMS level, a Project Monitoring Meeting shall be held quarterly, and chaired by the Project Manager of the PMT to be established at every FMS-MoH with technical staff, the Component 1 contractor representatives, and Regional Health Officials from Component 1 implementing regions.

23. **Project implementation will be phased to ensure successful initiation of project activities within available capacity, while implementing capacity development activities.** To help navigate project implementation, the Project Operations Manual (POM) will be prepared by the PCIU for submission to the World Bank for No Objection within two months of project effectiveness. The POM will describe the project components and activities; implementation modalities for each project component; fiduciary/disbursement and environmental and social safeguard responsibilities and arrangements; and coordination mechanisms at different levels. The POM will also include the monitoring of the project progress according to the Project's results framework. Sequencing of key project activities will allow the Government to ensure steady project implementation progress, while identifying and addressing capacity gaps using a flexible approach.

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APPROVAL

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