Project Information Document (PID)

Appraisal Stage | Date Prepared/Updated: 25-Apr-2022 | Report No: PIDISDSA34158

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Project Name	Parent Project ID (if any)
Djibouti	P178033	Djibouti Health System Strengthening	
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
MIDDLE EAST AND NORTH AFRICA	13-Apr-2022	26-May-2022	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	Republic of Djibouti	Ministry of Health	

Proposed Development Objective(s)

To improve the utilization of quality reproductive, maternal, neonatal, child, adolescent health and nutrition (RMNCAH-N) services, with priority given to underserved areas, refugees and host communities

Components

Component 1: Strengthening service delivery platforms
Component 2: Strengthening institutions, citizen engagement and project management
Component 3: Contingent Emergency Response Component - CERC

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	19.50
Total Financing	19.50
of which IBRD/IDA	19.50
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	19.50
IDA Credit	19.50

Environmental and Social Risk Classification

Substantial

Decision

The review did authorize the team to appraise and negotiate

B. Introduction and Context

Country Context

1. **Djibouti has a geographically strategic location for international trade and security.** Djibouti is a small lower middle-income and highly urbanized country of just under one million people located on the northeast coast of the Horn of Africa (HoA). Djibouti's geographic location gives it an advantage in terms of international maritime trade and security. About 30 percent of global shipping travels through Djibouti's waters and 85 percent of Djibouti port throughput is linked to landlocked Ethiopia. Djibouti hosts many international military bases, including those of China, France, Italy, Japan, Saudi Arabia, Spain, the United States, and others.

2. **Djibouti's economy has come under immense stress due to the COVID-19 pandemic in 2020, and more recently due to the conflict situation over the past year and a half in neighboring Ethiopia.** Djibouti's output growth is expected to reach 4.3 percent in 2021. Year-on-year (y/y) inflation rose by 2.5 percent at the end of 2021, driven by the recovery of domestic demand, high global commodity prices, and recurrent shortages in imports of fresh food from Ethiopia. On the fiscal front, the overall deficit of the central government remained low at 1.8 percent of GDP in 2021, owing to the rationalization of wages and salaries and the reduction of transfers to state-owned enterprises (SOEs) that offset the fall in tax revenues resulting from generous new exemptions introduced in the 2021 finance bill and continued pandemic-related tax reliefs. Despite the declared truce on March 24, 2022, further disruptions due to the prolonged crisis in Ethiopia and the lower confidence level generated by the state of emergency are expected to have a substantial and negative spillover onto Djibouti's economy. GDP growth in Djibouti could hover between 2.7 and 4.3 percent in 2022. Furthermore, humanitarian and security costs resulting from potential migratory movements from Ethiopia would exacerbate fiscal fragility created by the COVID-19 pandemic. As a net importer of food and energy, the economic consequences of the Russian invasion of Ukraine, war and associated sanctions would likely affect Djibouti's external account through higher import bills.

3. **Although classified as a lower-middle-income country, high rates of inequality persist, as reflected in a Gini coefficient of 0.42**. Despite recent economic growth and trend of decreasing inequality, an estimated 17 percent of Djiboutians live in extreme poverty (less than US$ 1.90/day) based on the 2017-18 household survey. This extreme poverty rate is estimated to have increased to 23-30 percent due to the impoverishing effects of the COVID-19 pandemic. Poverty is pervasive in Djibouti with 74 percent

of refugees living on less than US$3 per day[1]. While rural areas comprise only 15 percent of the total population, they account for 45 percent of the poor.

4. **Significant gender inequalities persist in Djibouti, throughout the lifecycle.** Rural women with low levels of education and poor socio-economic status as well as female refugees suffer disproportionately from the multisectoral effects of gender inequalities. The persistence of harmful gender norms affects access to productive resources and limits progress towards gender equality. School enrollment in general and in technical education is growing, but the female-to-male enrollment ratios (82 percent in primary, 72 percent in secondary and 61 percent in higher education) show an increase in gender gaps with years of education. Unequal access to quality health services particularly affects the sexual and reproductive health of women. The multiplicity of measures taken to economically empower women did not necessarily promote their equitable access to economic opportunities. The prevalence of Female Genital Mutilation (FGM) [2], despite being illegal[3], remains one of the highest in Africa (93 percent) and is a strong impediment to women's human and economic development opportunities.

5. **Food insecurity, exacerbated by the conflict in Ukraine, compounds Djibouti's human development challenges.** According to the 2021 Global Hunger Index (GHI),[4] Djibouti ranks 99th out of 116 countries with a GHI score of 27.4. Only about 1,000 square kilometers or 0.04 percent of the country's total land area is considered arable. According to the World Food Program (WFP), 90 percent of food is imported. About 10 percent of the population are food insecure and among them, 60 percent live in rural areas and depend on agriculture-based livelihoods. The ongoing conflict in Ukraine has already had an impact on global wheat prices and is likely to have a significant impact on food access in Djibouti since over 80 percent of wheat demand is met by imports. This demand is expected to be even higher during the month of Ramadan (April/May 2022) and supply may be further hindered by potential export restrictions from Russia and Ukraine to meet their domestic wheat demand should the conflict continue.

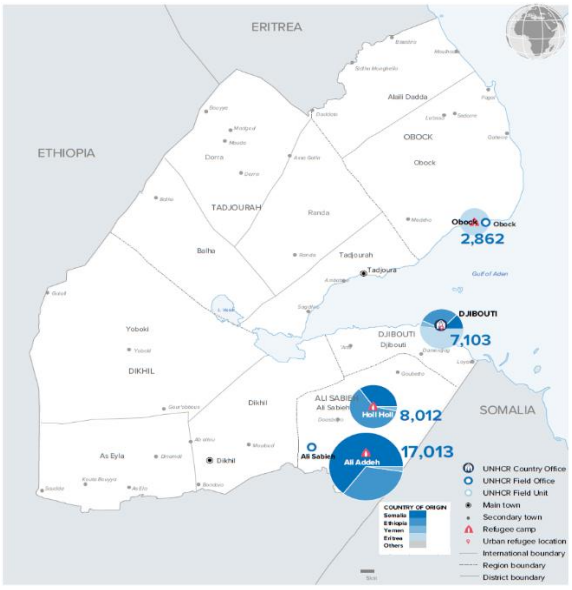
6. **In addition, Djibouti's high vulnerability to climate change constrains human and economic development**. While the strategic location defines much of Djibouti's current economic growth strategy, location is also a concern when considering the impacts of climate change and the expected trends likely to be seen in the coming years. The Notre Dame Global Adaptation Initiative (ND-GAIN) Index places Djibouti at 117 out of 181 countries due to its very high vulnerability to impacts of climate change; Djibouti is expected to experience adverse impacts from increased temperatures, increased aridity, reduced precipitation, and rising sea levels. Mean annual temperatures are projected to increase by 1°C every twenty years, with monthly average temperatures expected to rise by 1.9°C by 2050 and a staggering 4.5°C by 2100. These temperature increases are likely to be associated with intense heat waves, with cold spells and cold nights expected to decrease, which will have significant consequences for human and animal health, biodiversity, and water resources.

[1] United Nations High Commissioner for Refugees (UNHCR), 2017 data.
[2] United Nations strives for full eradication of FGM by 2030.
[3] Djibouti prohibits the practice of FGM through Article 333 of the Penal Code, which criminalizes and punishes its performance; Subsequent amendments to the law have included criminalizing the failure to report FGM and aiding and abetting the practice.
[4] https://www.globalhungerindex.org/djibouti.html

Refugee Situation in Djibouti

7. **The country's stability in an unstable region has made it an attractive destination for refugees from neighboring countries since the 1970s.** Per the United Nations High Commissioner for Refugees (UNHCR) estimates, as of February 28, 2022, Djibouti is hosting 34,990 registered refugees and asylum seekers. Refugees and asylum seekers are concentrated in three regions: Djibouti City (7,103), Ali Sabieh (25,025) and Obock (2,862), as shown in Figure 1. There are two locations within Ali Sabieh - Ali-Addeh (17,013) and Holl-Holl (8,012). These numbers represent the total number of both refugees and asylum seekers, while the count of only refugees in these locations is: 5,864 in Djibouti City, 2,813 in Obock, and 14,743 in Ali Sabieh (11,797 in Ali-Addeh and 2,946 in Holl-Holl). This represents a total of 8,865 households with 3,033 of them being in Djibouti city, 2,454 in Holl-Holl, 4,442 in Ali-Addeh, and 1,614 in Obock. The current number of refugees and asylum seekers constitutes about 3.4 percent (2.34 percent if taking into account only refugees) of the total population living in Djibouti, putting it within the countries with the highest ratio of refugees to local population in the world. Around three-fourths of refugees are women and children.

Figure 1: Map of refugee and asylum-seeker populations in Djibouti, as of February 28, 2022



Source: UNHCR

8. **In line with the Global Compact on Refugees, the government of Djibouti has maintained an open-door policy for refugees for the past four decades.** A National Refugee Law was adopted by the Djibouti Parliament in 2016 and promulgated in 2017. The law provides a legal framework for the protection of refugee rights, including access to basic services such as health. The law grants all rights enjoyed by Djiboutians to refugees, with the sole exception of the right to vote. The new law facilitates integration of refugees and host communities and is implemented through two decrees, including the

right to movement and access to legal employment and social services such as health and education. The Government strategy to support refugees has three pillars: (i) "*institutional and legislative strengthening*", which includes progressive reforms to facilitate the implementation of the National Refugee Law and inter alia encompasses better integration of refugees into labor markets, facilitate registration, and help gain access to civil documentation; (ii) *"improving access to basic services, particularly education and health"*[5] which consists of improving the quality of health services in host communities by enhancing existing facilities and training health personnel, integrating health facilities into the national public health system, and strengthening the national epidemiological and endemic surveillance and monitoring systems; and, (iii) "*social protection and economic promotion*", which attempts to ensure that refugees and host populations have access to adequate social assistance by extending universal health coverage (UHC) and the cash transfer programs to refugees, and promoting economic opportunities.

Sectoral and Institutional Context

9. **Djibouti's health outcomes have improved over the last two decades, generally surpassing the Horn of Africa (HOA) averages but lag behind those of peer lower-middle-income countries as well as Middle East and North Africa (MENA) countries** (Table 1)**.** However, the country performs worse than HOA averages in two child health indicators: neonatal mortality rate and severe wasting. Djibouti's under-five mortality rate (U5MR) of 58 deaths per 1,000 live births and maternal mortality ratio (MMR) of 248 maternal deaths per 100,000 live births are almost three and five times higher than MENA.

[5] The Government has demonstrated its commitment to integrating refugee populations in the national health system as evidenced by proactively rolling out the COVID-19 vaccinations for these populations.

Table 1: Key maternal and child health outcomes for Djibouti, select comparator countries and MENA[6]

	Mortality			Stunting	Wasting	Total fertility rate	Total health spending	Government health spending	
	Maternal	Neonatal	Under-5						
	per 100,000	per 1,000	per 1,000	%	%	per woman	% of GDP	% of GDP	% of budget
Djibouti	**248**	**31**	**58**	**34**	**22**	**2.7**	**2.3**	**4.3**	**1.2**
Most similar countries									
Cabo Verde	58	9	15	-	-	2.2	5.4	10.4	3.2
Kyrgyz Republic	60	12	18	12	2	3.3	6.5	8.4	2.8
Dominica	-	28	35	-	-	1.9	6.6	7.0	4.3
Jordan	46	9	16	8	2	2.7	7.8	12.4	3.8
Togo	396	25	67	24	6	4.3	6.2	4.3	1.1
Regional averages									
MENA[b] region	**52**	**11**	**20**	**16**	**6**	**2.8**	**5.6**	**3.1**	**9.2**
Excluding HICs[c]	58	13	22	17	6	2.9	5.9	2.9	9.2
Horn of Africa[d]	452	28	58	36	8	4.3	3.2	0.9	3.8

Source: Merchandise export diversification is the latest available year from UNCTAD Stat, United Nations Conference on Trade and Development. All other indicators are the latest available year from World Development Indicators, World Bank

10. **Poor nutrition outcomes for children are pervasive across the country and are often linked to incidence of diarrheal diseases in childhood and increased risk of non-communicable diseases (NCD) in adulthood.** Undernutrition accounts for 57 percent of deaths among children under five; it is widespread, with 17 percent underweight and 25 percent stunted with no gender differentials. The stunting rate is higher among rural (34 percent) than urban children (19 percent). Some lagging regions experience higher

[6] *Notes:*

a) Based on a "dissimilarity index," constructed as follows: Total population, GNI per capita, official development assistance as a share of GNI, and merchandise export diversification where each is standardized by taking the z-score across countries. Each country of the 138 with sufficient data was compared to Djibouti, and the resulting sum of squared differences across the four standardized variables is the index.
b) Middle East and North Africa, World Bank classification
c) High-income countries (HICs), according to the World Bank FY22 classification
d) Djibouti, Eritrea, Ethiopia, and Somalia
e) For consistency across countries, this table employs nutrition estimates from the UNICEF-WHO-WB Joint Child Malnutrition Estimates, which indicate a substantially higher rate of stunting than found by the Djibouti 2019 SMART survey.

burden of stunting: 40.2, 33.3, and 32.6 percent in Obock, Dikhil and Tadjourah, respectively. At the same time, deaths due to non-communicable diseases (NCDs) such as ischemic heart disease, stroke, cirrhosis, and diabetes have increased significantly between 2009 and 2019.

11. **Despite past investments, health infrastructure gaps remain, especially outside of Djibouti City and organization of services is sub-optimal**. Nationally, there are 3.2 maternity beds for every 1,000 pregnant women, well below the World Health Organization (WHO) recommended number of 10 per 1,000 pregnant women. There are 10.7 hospital beds per 10,000 inhabitants, of which only 51 percent are functional. Facilities do not have adequate basic inputs for their operations. Trauma services are only for stabilization of patients and air ambulance transfer. The organization of service delivery does not consider factors beyond geographical access to maximize quality of care and user confidence. Referral mechanisms are underdeveloped. As a result, the organization and networking of care is less than optimal.

12. **Djibouti has experimented with innovative financing mechanisms which have shown some promise in improving quality and quantity of services.** Djibouti has implemented the first generation of Performance Based Financing (PBF) through the Improving Health Systems Performance project (*Projet d'Amélioration de la Performance du Secteur de la Santé* or PAPSS). The PBF scheme was designed to enable contracted health facilities to have the autonomy to use earned funds for non-salary operating costs, basic maintenance, the purchase of drugs and consumables, and to incentivize facility staff through performance bonuses. This scheme has shown some progress in the quality of health services provided at the facility level with the quality score increasing from 19.61 percent in Q3 2018 to 43 percent by Q1 2021. However, these scores were significantly below the 60 percent which is the acceptable standard. Quantity indicators showed far better improvements with the number of women completing two or more antenatal visits increasing from 6,100 in June 2014 to 111,987 in March 2021, and percentage of children fully immunized increasing from 32 percent in December 2012 to 62 percent in December 2020. The government is planning to pilot a Direct Facility Financing (DFF) scheme. The DFF is similar to PBF since it finances non-salary operating costs at the facility level. As it is not linked to performance indicators, or their verification and does not finance performance bonuses for staff, DFFs are significantly cheaper to administer. Here, facilities are paid after conditions in the DFF contract such as management arrangements, previous period fund utilization and transparent use of funds have been met.

13. **Service delivery optimization can increase RMNCAH-N attainment.** UHC aims to provide full population access to an essential package of health services without the risk of financial hardship; universal *effective* coverage advances this concept by accounting for health services that meet minimum quality standards, setting the goal that every person gets the right care at the right place at the right time, every time. High-functioning health facilities are few and there are great urban-rural disparities in service coverage. Only 44 percent of health facilities are equipped for Basic Emergency Obstetric and Newborn Care (BEmONC), and just 5 percent have Comprehensive Emergency Obstetric and Newborn Care (CEmONC) capabilities.[7] Quality of care is a particular concern: the maternal mortality rate remains high

[7] Emergency Obstetric and Newborn Care (EmONC) is a package of life-saving interventions in the peripartum period; basic (BEmONC) can be delivered at lower-level health facilities (e.g. health centers) and includes interventions like parenteral medicines or assisted vaginal delivery, while comprehensive (CEmONC) requires greater concentration of resources such as a hospital can provide and includes interventions like blood transfusions and Cesarean deliveries.

even despite high skilled birth attendance, and timeliness of patient-centered care is a pervasive issue. Inefficient matching of health service supply with need limits the value of health service delivery by decreasing effectiveness and/or increasing cost. Appropriate matching of health need with level of care can ensure that the resource-intensive hospital platform is reserved for the relative few with emergent, complex, or highly specialized health needs (e.g., cesarean delivery), while less resource-intensive primary health service delivery platforms can therefore serve the relative many with low-acuity, low-complexity health needs (e.g., antenatal management of gestational diabetes). Such matching—termed **health service optimization**—improves effectiveness, efficiency, and patient-centeredness when distributed geographically, and is therefore critical to delivering universal effective coverage.

14. **Various demand-side barriers also remain**. Harmful socio-cultural beliefs and practices hinder health seeking behaviors and good health outcomes. Ninety three percent of girls and women have undergone the FGM procedure most commonly between infancy and age 15. Transportation, difficult terrain, and heat all contribute to lower demand for services, including low ANC and postnatal visits. Financial barriers to care are significant, particularly for the poor in rural areas and the refugees and poor in Balbala, where poverty is particularly high. While there is a basic package of services for primary care, certain medicines and laboratory tests are not covered, adding to the financial burden on families and thus further increasing barriers to adequate care. At the population level there is little citizen engagement and patient empowerment, and thus little social accountability.

15. **Inadequate management of health care waste is part of the health infrastructure gap.** Despite investments in constructing five artisanal incinerators, as part of the PAPSS project, the country's capacity to manage health care waste (proper segregation and treatment) remains extremely limited due to the lack of physical infrastructure and trained personnel. In addition, poor management of incinerators might shorten their lifespans.

16. **Human resources for health (HRH) are a key supply-side constraint**. Many health sector weaknesses stem from the low numbers and limited capacity and motivation of health workers across Djibouti. In 2017, there were 1.4 general practitioners, 3.5 nurses, and 2.2 midwives respectively, for a total of 7.0 medical personnel per 10,000 inhabitants[8] compared to the WHO recommendations of 44.5 doctors, nurses, and midwives per 10,000 inhabitants as the minimum density required to provide UHC.[9] Outside of Djibouti City (with a total of 9 medical personnel per 10,000 inhabitants), there are some regions with particularly severe HRH shortages: fewer than 0.6 general practitioners per 10,000 inhabitants and fewer than 1 midwife per 10,000 inhabitants in Tadjourah, Ali-Sabieh, and Dikhil; and just over 2 nurses per 10,000 inhabitants in Dikhil and Tadjourah.

17. **Community health programs are nascent and fragmented.** Overall, the Djibouti community health platform is made up of community health agents, community relays, women mobilizers, and health committees. Community health agents have been recruited into the civil service, put on the civil service

[8] Government of Djibouti, 2020. *Plan National de Développement Sanitaire 2020-2024*.
[9] World Health Organization, 2016. *Health workforce requirements for universal health coverage and the Sustainable Development Goals*. Human Resources for Health Observer, 17.

payroll, further trained, and converted into facility-based providers who do not engage directly with communities. The Ministry of Health (MOH) has a network of community health worker (CHW) volunteers, but they are not currently functional due to lack of funding. In addition, the Ministry of Social Affairs and Solidarity's (*Ministère des Affaires Sociales et des Solidarités*, MASS) community health agents are currently conducting nutrition outreach, but only in Arhiba, Balbala and Obock.

18. **Other supply-side issues include governance, capacity, and institutional challenges.** Decentralization, coordination, and accountability are key institutional challenges for the health system. The capacity of key institutions for stewardship or for service delivery is limited. Various important sub-sector policies, strategies, regulations, standards, and norms are yet to be developed, especially in the context of decentralization. Beyond the PBF scheme that was put in place under the recently closed Bank-financed PAPSS project, accountability mechanisms in health care are nascent.

19. **At US$71 per capita per year, Djibouti spends relatively less on health compared to other lower-middle income countries (US$98 on average) and MENA (excluding high-income) (US$521)**. Prepayment for health service, a core tenet of UHC, accounted for about half of total health expenditure while out-of-pocket spending (OOPS) accounted for 29 percent and was the second largest source of financing in 2018. Although OOPS in Djibouti compares favorably to other lower-middle income countries, upper-middle income countries, or MENA (excluding high income countries) where average OOPS is 51, 33 and 41 percent, respectively, this might be due to foregone care. Legally, primary and secondary health services are free and available to both Djiboutians and non-nationals at government facilities, however, tertiary care is largely paid out-of-pocket.

Health Service Needs and Access Among Refugee Populations

20. **The government has made concerted efforts to integrate health services for refugees into the national health system.** The government continues to integrate health centers in refugee villages (camps) such as in Ali Addeh, promoting both host communities and refugees to use the same health centers. Registered refugees have had access to a parallel primary health care system initially set up as part of humanitarian assistance in camps. However, in January 2018, the MOH and the UNHCR signed a cooperation agreement for the inclusion of refugees in the national health system. Another agreement between the MASS, the World Food Programme (WFP), and UNHCR in 2019 made provisions for the inclusion of refugees and asylum seekers in public health insurance, supported by a socioeconomic profiling exercise of all refugees and asylum-seekers expected to result in the inclusion of 12,500 vulnerable refugees in the Social Health Assistance Program (*Programme d'Assistance Sociale de Santé,* PASS).

21. **Development partners are engaged in the health sector and on the refugee agenda in Djibouti**. The United Nations Children Fund (UNICEF) focuses on building community structures for health service delivery accountability, working both on the demand for and supply of health services. It also has a strong focus on nutrition, given the high rates of stunting and malnutrition in Djibouti and is currently planning to use the community platform for improving nutrition indicators among children. UNICEF supports 33

health posts that contain nutrition units. UNHCR is engaged on the refugee agenda in Djibouti, given the high numbers of refugees and asylum seekers. UNHCR is supporting the integration of health services across refugee camps and host communities, via an annual plan of action developed each year and overseen by a team housed in the MOH's Directorate of Health Regions (*Direction des Régions Sanitaires*, DRS). The Global Fund is financing the three diseases - malaria, HIV/AIDS, and tuberculosis - and is currently exploring ways, in collaboration with the Bank, to support the Djiboutian Government on further advancing the refugee agenda. Other development partners active in Djibouti in the health sector include, for instance, the European Union, who are funding a nutrition project, and the Japanese government, through World Bank-administered grants.

C. Proposed Development Objective(s)

Development Objective(s) (From PAD)

To improve the utilization of quality reproductive, maternal, neonatal, child, adolescent health and nutrition (RMNCAH-N) services, with priority given to underserved areas, refugees and host communities

Key Results

The Project Development Objective (PDO) indicators will be:

i) Percent of children fully immunized before their first birthday
ii) Percent of pregnant women having 4+ ANC visits with 3+ malaria intermittent preventive treatment doses
iii) Percent of births in appropriate facilities[10]
iv) Number of women having at least 1 postpartum visit within 1 week after birth
v) Average facility quality score as assessed by the PBF quality check list[11]

All service utilization indicators, both at the PDO and intermediate levels, will be monitored for refugees, residents of host communities, and by gender (where meaningful).

22. The project will be financed by a US$14.5 million equivalent IDA credit and a US$5 million equivalent grant from the Window for Host Communities and Refugees (WHR). The scope of the project is nation-wide, with priority given to refugees, host communities, and underserved populations living in the five regions and other areas such as Balbala, a suburb of Djibouti City. The operation will consist of three components as follows:

Component 1: Strengthening service delivery platforms (US$16.5 million, of which US$4 million from the WHR).

[10] Appropriate facilities are defined as facilities either (i) offering Comprehensive Emergency Obstetric and Neonatal Care (CEmONC) or (ii) within 5 km of facilities with CEmONC.
[11] For different levels of care, there are different sets of criteria to measure quality (availability of services, hygiene practices, data management, etc.). Each facility is rated on the extent to which criteria are met.

- *Subcomponent 1.1: Service delivery optimization*: This sub-component refers to the service delivery redesign agenda.[12] Activities include support for:

  i) Development of a national health service optimization plan
  ii) Rehabilitation of health facilities, transformation of existing building into maternal waiting homes, and rehabilitation of the central drug store (*Centrale d'Achat des Medicaments et Matériels Essentiels* - CAMME) according to the service optimization plan
  iii) Support the supply of essential medicines (following a review of procurement process for essential medicines) and medical equipment
  iv) Improvement of the biomedical waste management system
  v) Provision of mobile clinics and electric/hybrid/hydrogen-powered buses
  vi) Development and implementation of a referral and counter-referral strategy
  vii) Improving RMNCAH-N workforce

- *Subcomponent 1.2: Supporting the PBF and Direct Financing Facility (DFF) schemes:* This subcomponent supports the financing and implementation of PBF at primary, secondary and tertiary levels, and the DFF pilot in two regions at primary level.

- *Subcomponent 1.3: Supporting the community health platform:* This subcomponent supports the MOH in the development and rollout of a community health worker program to deliver a comprehensive community health package.

Component 2: Strengthening institutions, citizen engagement and project management (US$3 million, of which US$1 million from the WHR). This component aims to strengthen the government's capacity to implement and coordinate programs, within the MOH, across other ministries and agencies on cross-sectoral issues (e.g., stunting, FGM, refugees), and between the central government and regional hospitals.

- *Subcomponent 2.1: Strengthening institutions:* This subcomponent will provide technical assistance (TA) and capacity building for various institutions which are critical to RMNCAH-N.

- *Subcomponent 2.2 Social mobilization for health:* This subcomponent will support positive behavior change for better health, help ignite people's demand for better services and amplify people's voices.

Component 3: Contingent Emergency Response Component (CERC) (US$0 million). A CERC is included in the project in accordance with Investment Project Financing (IPF) Policy, paragraphs 12 and 13, for

[12] Kruk ME, et al. High-quality health systems in the Sustainable Development Goals era: time for a revolution. Lancet Glob Health. 2018 Nov;6(11): 1196-1252.

Situations of Urgent Need of Assistance and Capacity Constraints. This will allow for rapid reallocation of credit and grant uncommitted funds in the event of an eligible emergency as defined in OP 8.00.

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

23. Overall, the project is expected to have positive environmental and social impacts as it will contribute to improving the health service delivery of essential health care, institutional capacity building in rural areas where current services are quite limited. The project will include financing of minor civil works that involve the renovations of existing health centers to improve their capacity to adapt to climate change or to convert existing structures into maternity waiting houses, the acquisition of medical equipment, including an incinerator, community awareness activities, technical assistance and trainings. It will lead to generic and site-specific environmental and social risks and impacts related to civil works, such as moderate dust emissions, debris, noise, and other solid waste generation, exposure to COVID-19, sexual exploitation and abuse and sexual harassment and occupational health and safety.

24. But more fundamental are the key environmental and social risks associated to the exploitation of the project renovated infrastructures and use of project-financed acquisitions. With the improved delivery and enhanced access of health services through the project in rural areas, the quantity of health care medical waste will likely increase in a context where most health care facilities do not have appropriate regulations or management systems. A lack of awareness about the health hazards related to healthcare waste, inadequate training in proper waste management, absence of waste management and disposal systems, insufficient financial and human resources and the low priority given to the topic are the most common problems. The main anticipated risk associated with mismanaged health care waste are environmental and community health risks, labor conditions related risk (the availability and supply of personal protective equipment for healthcare workers). Fire in health care facilities represent another significant risk due to the storage, handling, and presence of chemicals, pressurized gases, boards, plastics, and other flammable substrates. Other social risks include elite capture and/or the exclusion of vulnerable and disadvantaged groups and individuals from project benefits, in particular in security access to transportation vouchers.

25. An Environmental and Social Management Framework (ESMF) has been prepared to provide guidance regarding the instruments that may need to be prepared during the project implementation, such as Environmental and Social Management Plans (ESMPs). The ESMF includes screening procedures to identify whether civil works lead to physical or economic resettlement impacts and health structures to be renovated that contain asbestos. Any subproject with such impacts will be automatically excluded.

Moreover, the ESMF outlines the selection criteria that will determine the facilities that will benefit from the project, a biomedical waste management plan, and Life and Fire Safety recommendations that is consistent with World Bank Group Environmental, Health and Safety Guidelines for Health Care Facilities for structures benefiting from renovations, WHO standards and specific COVID-19 related measures. Finally, the ESMF details the project's grievance mechanism. Environmental and social risks of all project activities, including those that are measured under performance-based financing (PBF), such as those under subcomponent 1.2, will be managed under the ESMF.

26. In addition to the ESMF, the following instruments will be prepared by the client: The Environmental and Social Commitment Plan (ESCP), the Labor Management Procedures (LMP) and the Environmental and Social Management Plan (ESMPs).

E. Implementation

Institutional and Implementation Arrangements

27. Consistent with the strategic orientations of the Government of Djibouti to build capacity of government staff and building on the lesson learned from Bank-supported projects' implementation challenges, the project will be implemented within the existing institutional structures within the MOH and include personnel with experience in previous Bank operations. The new operation will be coordinated by the Office of the Secretary General and overseen by a project steering committee. The Project Management Directorate (DPG) will be in charge of the day-to-day management of the project. Other relevant directorates within the MOH will make up the project's technical team and will be supported by consultants retained from the PAPSS project as well as additional specialists in key areas where additional capacity is required, such as fiduciary, environmental, and social, and monitoring and evaluation. In addition, the Ministry of Finance (MOF) will exercise its fiduciary responsibility to ensure that project proceeds are used for intended purposes. Given that refugee programs are coordinated by the Ministry of the Interior (MOI), that pre-service training is under the mandate of the Ministry of Higher Education and Research (MOE), and that the community platform has overlaps with community workers managed by the Ministry of Solidarity and Social Affairs (MASS), the MOH would have a coordination responsibility with relevant ministries as well as other relevant committees and agencies, such as the National Committee for the Abandonment of All Forms of Excision. In addition, the MOH will coordinate closely with all development partners, including UNICEF, United Nations High Commissioner for Refugees (UNHCR), United Nations Joint Programme (UNJP), WHO, Global Fund, etc.

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